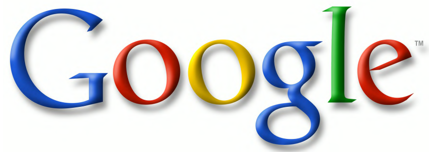

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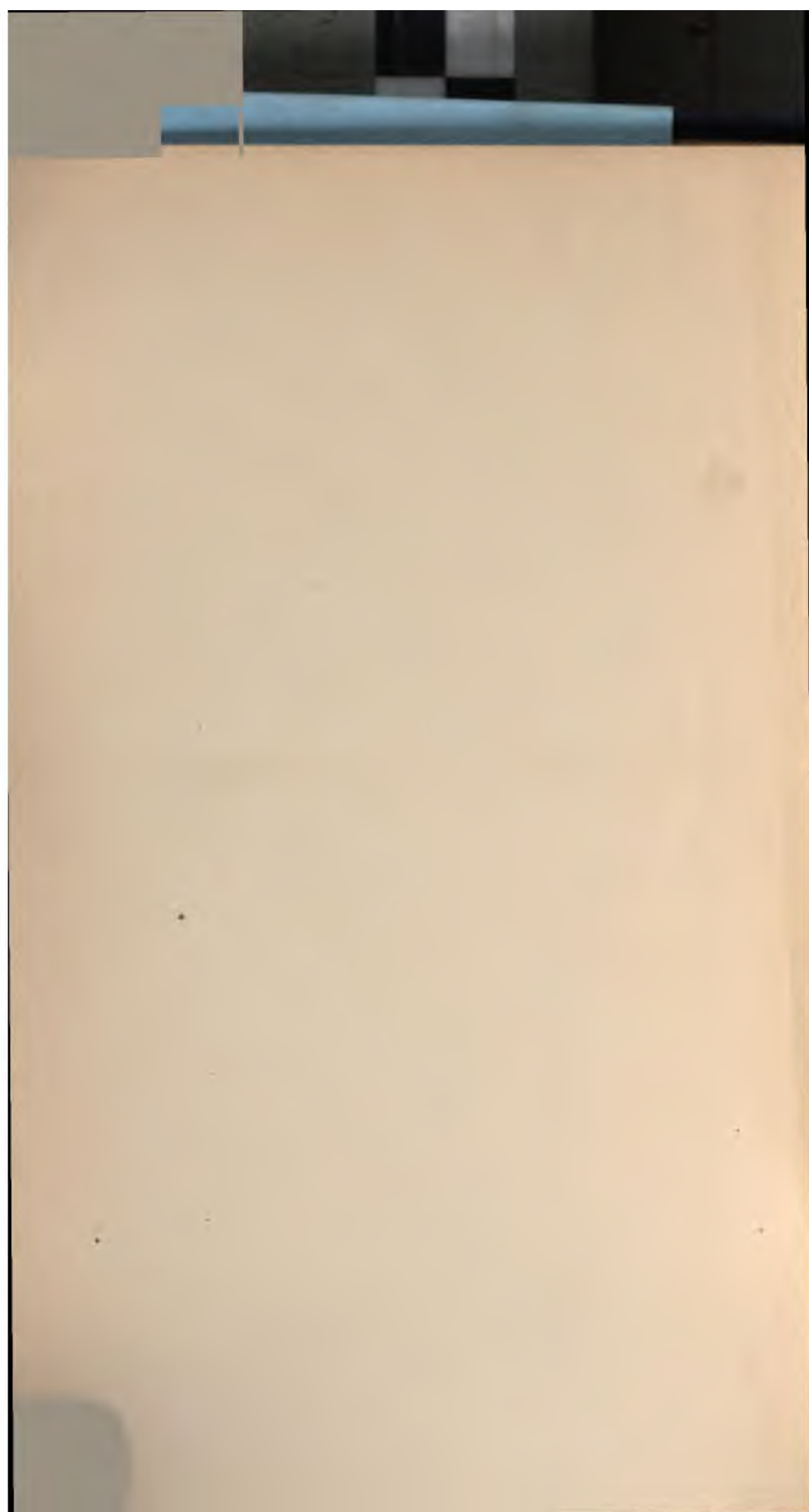

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A PRACTICAL TREATISE
ON THE CAUSES, SYMPTOMS, AND

TREATMENT OF SEXUAL IMPOTENCE

AND OTHER SEXUAL DISORDERS
IN MEN AND WOMEN

BY

WILLIAM J. ROBINSON, M. D.

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PREFACE

The author has always entertained somewhat peculiar ideas about books, and he has not hesitated to express them. Those ideas are crystallized in his motto which he has put on the title page of every one of his books: "No book has a right to exist which has not for its purpose the betterment of mankind by affording either useful information or healthful recreation." I will go even further and say that a book that does contain useful information, but information which is already contained in other books previously published, has no right to exist, unless the author at least presents the matter from a new point of view, or classifies it in such a manner as to make its comprehension more easy, more assimilable. It is unfortunately only too true, however, that thousands of books are published annually which have absolutely no raison d'être, for they do not contain an atom of new information, nor does the arrangement of the subject-matter present any originality. They present merely a rehash of some other book or a resumé of several. And without mincing words it must be confessed that many a book owes its existence to one reason only: the author's desire for fame or financial emoluments or both. That this is a legitimate reason, I will admit; but it must be a secondary reason. The primary reason, the real mainspring

for getting out a book should be *service;* it must be serving humanity, or a portion of it, by giving it new information or information hitherto inaccessible, information based upon personal first-hand knowledge, or presenting it in a new systematized popular form.

Another point, which is more important than all other points combined: The author must be absolutely honest and fearless and if his opinions happen to run counter to those generally accepted he must state them unhesitatingly, without regard to consequences. I believe that judged by the above criteria, this book has a right to exist, for it contains some *new* information on the nature and treatment of sexual disorders, it presents the existing information in a clear, systematized form, so that the physician can make practical use of it in his daily practice, and the author states his views on certain mooted sexual questions with an unequivocal clearness and positiveness which certainly leave no doubt in the reader's mind as to just what the author wanted to say.

Will every physician, by the guidance of this book, be able to treat sexual impotence and other sexual disorders successfully? Yes, provided he possesses a modicum of common sense. No book, no system, no encyclopedia, no university will teach a man common sense if he is congenitally devoid of it. But to any physician possessing a fair share of sound sense and judgment — and these qualities should be prerequisites to the practice of

medicine — this volume should prove of inestimable value. In fact it is because the various articles on sexual subjects, which we published from time to time in the last few years, did prove of such great practical value, that we have decided to respond to the numerous *urgent requests* (sic) of the profession to get out a complete systematic treatise on sexual disorders and their treatment.

One of the most valuable and unique features of the book I consider the numerous case reports, which illustrate every phase of sexual disorder. Abstract descriptions of symptoms and treatment often leave but a faint impression on the reader's mind; descriptions of actual *individual* cases, giving the *individual* symptomatology or *individual* treatment, often become indelibly impressed on the memory, so that when a physician gets a case, he finds less difficulty in understanding and classifying it, and it is easier for him to order the correct treatment.

I have not tried to get out a big book, tho it would have been very easy to do so. It is easier to get out a big book than a small one (i.e. one which is small and nevertheless covers the ground). I have carefully avoided padding. Thus for instance I have not included a chapter on the anatomy of the sexual organs, which every writer on sexual disorders thinks it his duty to do. And for a very good reason: Our standard anatomies contain descriptions of the sexual organs which are perfect in all details. If a writer wants his book to contain an an-

atomical chapter he must copy from the standard text-books verbatim; in which case his chapter is useless; or, as he generally does, he abbreviates, condenses, distorts, in which case his anatomical chapter is worse than useless. The best thing a physician can do if he wishes to refresh his memory in the anatomy of the sexual organs is to go and take out his Gray, Piersol, Cunningham, etc., and spend an hour or two among their pages. The same is true of the chapter on the physiology of the sexual organs. Nor have I even given the modus operandi and the various steps of the sexual act. I did not think that any adult was in need of this information, and I have a lingering suspicion, that anybody who copies Rubaud's description of the sexual act (and every author does copy Rubaud, because nobody has yet risen above his poetic flight in this matter, and to attempt to excel him is a hopeless task), does so to satisfy the salaciousness which allegedly resides to a certain extent in every person, male or female, and to help the sale of the book.

De gustibus non est disputandum, but I do not like useless padding, and I detest *useless* salaciousness.

One word about the language. I never could see why text-books had to be written in a cold, impersonal manner devoid of the human touch. I have preferred to write this book in the language which I have employed for so many years in my editorial and other writings: personal, clear, straightforward, conversational. I have found this

to be not only the most honest, but also the most *impressing*, the most convincing way of writing. It carries the message straight home, and leaves a deeper impression on the reader's memory, than does the cold, solemn, impersonal, so-called literary style. Utilitarianism — practical usefulness — is the keynote of this book. I want the physician not only to understand what he reads; I want him to remember it.

PREFACE TO THE SECOND EDITION.

The exhaustion of the first edition in less than two months from the day of publication shows unmistakably the need of a book of this character. It also shows that the profession is at last becoming alive to its shortcomings in the matter of sexual disorders and is beginning to be willing to learn.

This edition has been revised and enlarged and a complete index has been added.

May 1st, 1913.

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INTRODUCTION

In their totality, the diseases and disorders of the sexual system and the aberrations of the sex instinct have been the cause of more suffering and more misery to the human race than any other class of diseases afflicting the human body. This being so, and the duty of the physician being to relieve physical suffering and mental agony arising from physical causes, it would seem that the study of sexual diseases would engross the deepest attention of the medical profession. This is far from being the case. Why?

There are three reasons for this neglect of sexual disorders.

First.—The general ignorance prevailing among the medical profession no less than among the laity, regarding the importance and significance of the sex instinct and its abnormalities. Speaking of sexual disorders, as distinct from venereal diseases, very few physicians appreciate the somber influence of sexual weakness, or non-satisfaction, or abnormal satisfaction of the sexual instinct on the man's and woman's psyche, on the mental, moral and physical life of millions of people.

Second.—The general insane attitude towards everything connected with the sexual system which has come down to us from the early, but particularly the middle,

centuries of the present era, in contradistinction to the sane attitude that prevailed, for instance, in ancient Greece. The sexual system became something shameful, disgraceful, any manifestation of the sex instinct became a nasty criminal thing, and a disease contracted during illicit intercourse, or a disorder resulting from some sexual abnormality, was a well-deserved punishment which had the full approval of God. And this generally contemptuous attitude towards everything sexual which prevailed in society influenced the medical profession also. The medical colleges neglected the study of the reproductive organs, both their physiology and pathology, as if they, the reproductive organs, were non-existent. It is only a short while since venereal diseases became a part of the medical curriculum, but sexual disorders are still unmentionable and unmentioned in our colleges. The result is that towards sexual disorders most or practically all our practitioners bring an amount of ignorance and a contemptuous, supercilious attitude which are very disgraceful and very disastrous to the patient. Some general practitioners refuse to treat genito-urinary or sexual disorders altogether, which is perhaps just as well and more honest, others take the patient's money, but they let the patient know that they consider such cases a nuisance. The result of this attitude of the profession towards venereal and sexual disorders has been to drive thousands of patients into the hands of conscienceless quacks and charlatans.

Just now there are signs of a saner attitude towards sexual subjects on the part of the medical profession, and we can say with pardonable satisfaction that we have had a considerable share in bringing about this change of attitude.

The Third reason for the cynical, blasé, neglectful attitude towards sexual disorders, is that they are in themselves not directly fatal. And a disease that has no mortality does not deserve serious consideration at the hands of our profession. It does not seem to have dawned yet upon the minds of our professional brethren that death is not the worst thing in the world; that there are conditions which are worse than death. A disorder that is extremely widespread, that causes physical suffering and psychic agony, that leads to shame, humiliation, disruption of the home, divorce, hypochondriasis, and not infrequently suicide, is certainly worthy of the attention of the members of a profession, that in its best traditions and best representatives has always been noble and humanitarian.

Let us hope that our profession will in the future devote more attention to the study of sexual disorders than it has in the past, and if this volume shall have, even in a slight degree, contributed towards a clarification of some obscure points, the author will feel amply repaid for his labor.

PART I

MASTURBATION

CHAPTER ONE

MASTURBATION: DEFINITION AND PREVALENCE

We begin the study of sexual disorders with the subject of masturbation, because masturbation is the most widespread of all habits or diseases, because almost the entire male half of the human race enters upon its sexual life with masturbation, and because it is masturbation that lays the widest foundation for numerous sexual disorders, the chief ones being pollutions, spermatorrhea, impotence and sexual neurasthenia. *If we could eliminate masturbation, we would eliminate one of the most important etiologic factors of sexual disorders and nervous diseases.*

The word masturbation, corrupted from the Latin words *manus* (hand) and *stuprare* (to defile) means the induction of a venereal orgasm and an ejaculation by friction with the hand. But the word has been extended to other objects than the hand, for the variety of objects used in practicing masturbation is, as we will see further on, extremely large. In fact I extend the word masturbation to cover any method of inducing an orgasm, except coitus with the opposite sex.

Indeed we have one kind of masturbation, the most dangerous and most weakening kind, in which no material object and no friction of any kind is used. I refer to psychic, mental, abstract, or ideational masturbation, in which the person, man or woman, induces an orgasm

by concentrating the imagination on lascivious pictures and performances, on the naked bodies of the opposite sex, on scenes of intercourse, etc. This, as stated, is the most dangerous and most injurious variety of masturbation because in order to induce an orgasm and ejaculation without any mechanical aid the sexual centers must be excited to their utmost and this causes their rapid and sometimes irreparable exhaustion.

When the habit is practiced, as it most commonly is, by the person upon himself or herself in solitude we speak of auto-masturbation. It is to this variety alone that the term "solitary vice" is applicable. Where the vice is practiced between two or several companions, we speak of mutual masturbation. While auto-masturbation is generally practiced in secret, it is not infrequently (in schools, etc.) practiced openly, in the presence of companions. This we may designate as public masturbation. We speak of manual masturbation, when the hand is used to induce the orgasm; instrumental, when some kind of appliance or instrument is used for the purpose.

Prevalence in the Male Sex.— If we consider masturbation a disease, it is the most widespread of all diseases. More widespread than all the venereal diseases combined, more widespread — in the male sex — than measles. There was a time when I used to assert with Berger that "out of one hundred men ninety-nine have masturbated at one time or another and the one-hundredth, the pure man, is a liar." But with greater experience, I have come to change this extreme opinion. There *are* men who have never masturbated. I have had patients in whom I could have the fullest confidence and who assured me most ear-

nestly that they never, not even once, had indulged in masturbation. It is true, that a man who will speak freely about the numerous gonorrheas he has had, who will not even hesitate to speak of his sexual weakness, will often conceal the truth about his addiction to self-abuse; but I am speaking of intelligent patients, who came to be treated, who were anxious to get cured, and who knew that it was important for me to know their exact previous sexual history. And still they denied ever having practiced masturbation. I therefore must accept their statements as the truth. And while exact percentages can of course not be given, still I would state it as my belief that the percentage of men who masturbate at one time or another ranges between 90 and 95. Yes, there are about 10 or 5 per cent of males who were never guilty of the so-called solitary vice. (I say so-called because in mutual masturbation the vice is not solitary.)

Prevalence in the Female Sex.— As to the prevalence of the vice in the female sex, we are all at sea; we have no reliable figures, and we haven't even any data to help us to make a decent guess. We can only go by impressions. The reason for this is a twofold one. First, girls and women appeal to us much less frequently for aid: the results on the whole are less injurious in them than in men, for *the principal disability for which men consult us, namely impotentia coeundi, does not afflict them.* And second, girls and women are very reticent on this subject. No matter how much they may suffer, even if they think that they will not get well unless they confess to the doctor everything, they will not confess the vice of masturbation. They are too sensitive on the subject. I

speak, of course, of the vast majority. A small percentage in their anxiety to get cured do overcome their false modesty and tell the doctor everything. The radical and emancipated women, whose ranks are constantly increaseing, are also learning to speak to the doctor with the same frankness that men do. So that we are beginning to get some data. Nevertheless we are obliged to go principally by our impressions in this regard. And my decided impression is that masturbation is not nearly so common in the female sex as it is in the male sex. And I will even go further, and say that those who claim that 100 per cent of all girls and women masturbate i.e., have masturbated at one time or another, do not know what they are talking about. Either this, or they deliberately exaggerate for the purpose of making a sensation. Ten to twenty per cent would be a liberal figure, and probably rather above than below the actual truth. There are some furious masturbators among women — just as the nymphomaniac woman is worse than any man in this respect, so there are worse masturbators among women than among men — but that does not militate against the fact that their number is much smaller.

Age. No age is exempt. Infants three months old of either sex, men and women of sixty and over have been known to masturbate. I have known a man of 76 who was an incorrigible masturbator, using different ways and means to bring about an orgasm and ejaculation. But of course the period at which masturbation is practiced most frequently is in the years immediately preceding and following puberty — the period between 10 and 24, or to make the limits narrowed, between 12 and 18. Under 10

or 12 the sexual instinct is not yet fully awake and children under that age who masturbate do so primarily on account of some local irritation; while after 18, the young man has usually learned of the injuriousness of the habit and begins to indulge in regular sexual relations, and after twenty-four is apt to be married.

Frequency. The frequency with which boys and girls addicted to the habit practice it varies greatly. Some will indulge in it once or twice a week, some once a day; still others will indulge 2, 3 or 4 times in one day, and then will refrain altogether for a week, or two or even three. The stories of boys and girls indulging 10 or 12 times an hour may be true, but they must be extremely rare and belong to the domain of the psychopathies. The most extreme case I have had under treatment, was that of a young man who masturbated when he got the "attack," 10 to 20 times in 24 hours. The ejaculated fluid during the last few times would be thin and very scanty, just a few drops, he would feel a burning and scalding instead of a pleasurable sensation, and still he would keep on and on until he'd fall completely exhausted and "dead." He would be in a wretched condition for three or four days, then he would begin to recuperate, and he would be all right for six or seven weeks. And he would not masturbate, not even have any desire to do so, until the next attack. This patient was completely cured, and he will be referred to again, in the chapter on treatment. Women do practice the vice with a frequency which is almost incredible. But on investigation all such extreme cases will be found to be nymphomaniacs, that is they belong to the domain of psychopathy, and that is a separate chapter.

We have known one "normal" woman, however, who masturbated six to ten times a day, two to three times a week. She was a complete nervous wreck when she applied for treatment. An adherent inflamed clitoris was the cause.

Station in Life. No station in life is exempt. It is prevalent in the very lowest as well as in the highest strata of society, among the most savage as among the most cultured nations. Some high class schools and colleges are hotbeds of masturbation. Though probably less prevalent in ancient times than now, it was well known in antiquity, and in the decadent period of Rome the evil was most widespread. Even animals deprived of their mates practice it. Monkeys in captivity become confirmed masturbators, and Voltaire thought that of the animal kingdom monkeys were the only animals addicted to the vice. But, we now know better. Dogs masturbate frequently, and horses sometimes indulge in the habit to such an extent that their health is materially injured.

Note.—In continental Europe the word onanism is in general use instead of masturbation. This use is etymologically incorrect, as the term onanism (Onan, see the Bible) should be applied to withdrawal only. I have never liked the terms onanism and onanist, and use exclusively masturbation and masturbator.

CHAPTER TWO

THE CAUSES OF MASTURBATION

General. What leads boys and girls into masturbation? The original primary cause is of course the existence of the sexual instinct. But what are the immediate causes? One great cause is initiation by other boys. The habit of masturbation would be much less widespread than it is, if boys and girls were not taught it by other boys and girls, or servants, or nursemaids, etc. One masturbating boy will sometimes infect an entire class, and from one class it spreads into other classes. A very large number however, according to my investigations, start the habit by themselves, unintentionally, and without any special cause. In fact I believe that the vast majority of boys would masturbate if they never were seduced or initiated by others. Through seduction the boy acquires the habit much earlier than he otherwise would, but acquire it he would eventually, anyway. The developing sexual instinct which is revolutionizing his entire body and psyche, which fills him with vague longings and strong though ill defined desires would eventually lead him into the habit. A boy will lie in bed, will get warmed up, through an accidental pressure or friction there will be a slight erection with a new, hitherto unexperienced, pleasurable sensation, the boy will touch the organ again — and before he knows just how it happened, an ejaculation has taken place and the mischief is done. He has had a novel ex-

perience and he is as a rule not slow in repeating it. The friction of the genitals against the clothes, particularly if tight, or sliding down banisters or climbing poles is often the first step towards masturbation. I have known cases where the first ejaculation took place during a friendly wrestling and rolling on the floor between two or several boys. These two causes — initiation or seduction by others and accidental initiation — are the most important. All other causes are secondary, but they must be mentioned, in order that we may avoid them in trying to institute an efficient system of prophylaxis.

Local. Irritation about the genitals due to any cause, phimosis, an accumulation of smegma under the prepuce, eczema on or about the genitals, prurigo, pruritus of undefined etiology, urticaria, scabies, seatworms, in short anything that will cause the child to handle or scratch the genitals will be conducive to masturbation. Constipation, which causes the boy to strain and thus sometimes induces an erection, is sometimes the inital cause. Sleeping in bed with another person is very bad. Unconsciously during the sleep an erection and ejaculation may be induced. The copulation of animals, generally dogs, in the streets, always watched with lascivious curiosity by boys of all ages, has a very injurious effect. More than one patient told me that that was the first thing that excited his sexual curiosity, gave him precocious knowledge and led him into the habit of masturbation. Obscene pictures and posters, lewd pornographic literature, gotten out with the deliberate purpose of debauching boys and girls, vulgar shows, have an undoubted pernicious effect on the youth of both sexes. They awaken the sex-

ual instinct prematurely, keep it always at high heat, with the result of inducing not only masturbation, but other sexual irregularities as well.

Long, immovable sitting in one place, in school or elsewhere, is very injurious for children, induces congestion about the genitals, and by the irksome nervousness which it causes may be a direct cause of masturbation.

The Objects Used for Masturbation. The various objects used for performing masturbation form a curious chapter in human perversity — or ingenuity. While the hand, being the most handy, is by far the most frequently used, there comes a time when the hand apparently ceases to give the desired satisfaction and stronger stimuli are used. And instead of external friction, endourethral and rectal masturbation is indulged in. The objects used for this purpose comprise lead pencils, penholders, catheters, steel sounds, glass tubes, glass rods, wax candles (gas lighters), paper cutters, cork screws, ladies' hatpins, canes, broomsticks, etc., etc. Medical literature contains numerous reports of various foreign bodies used for masturbatory purposes. In the *American Journal of Urology* for January, 1908, Dr. L. Buckle reports an interesting case of rectal masturbation in a man of seventy which will be referred to later on.

In the same journal for December, 1909, Dr. Franz Weisz of Budapest reports the removal of a wax bougie from the bladder by dissolving it with benzin. The candle was used in the urethra undoubtedly for masturbatory purposes, though the man claimed, as they always do, that he inserted it to facilitate urination.

As to the objects used by women, both married and

unmarried, for the purpose of masturbation, their name is in truth legion, and it is sometimes hard to believe that a sane human being could use the things that we are occasionally called upon to remove from the female genitalia. Leaving out the various objects, often in the shape of the membrum virile, which from the most ancient times were manufactured specially for the purpose of female masturbation, the commonest object is the woman's most handy implement, the hairpin or hatpin. And we often have to remove hairpins and hatpins from the female bladder and vagina. Corks, ointment jars, pocket knives, rubber balls, paraffin candles, pessaries, perfume bottles, spoons, billiard balls, apples, carrots, etc., etc., are a few of the things which the poor girls and women use to induce an orgasm and which, slipping beyond their control, must occasionally, to their intense humiliation, be removed by the hand of the physician.

They often suffer in silence for a long time, and only when the suffering becomes unbearable, or when the people about them begin to notice that there is something wrong with them, do they appeal reluctantly to the physician.

In one case the object — a small stick capped with a piece of sponge — which slipped beyond the girl's control remained in the vagina for nearly three months, before the girl applied for help. I had quite some difficulty in removing it, as it had become imbedded in the tissues, and produced a severe ulceration and a profuse horribly ill-smelling discharge.

CHAPTER THREE

THE RESULTS AND SYMPTOMS OF MASTURBATION

It is no longer a subject of dispute that the evil results of masturbation were terribly, shamefully, stupidly, if you will, exaggerated by the older doctors. Whether they were truly convinced that the results of masturbation were as horrible as they portrayed them, or whether they did it with the pious intention of frightening those addicted to the habit and to prevent new victims is immaterial. Probably both hypotheses are correct. The older physicians were not given to scientific analysis and they were constantly guilty of the *post hoc, propter hoc* fallacy. They saw a tabetic patient or a lunatic who had been or was masturbating and they immediately jumped to the conclusion that that man had tabes or was insane *because* he masturbated excessively. It didn't come to their mind that it was possible that the man masturbated excessively because he was getting tabes or because he was a lunatic. As to the lurid colors in which they pictured the dire consequences of masturbation, they had a more disastrous effect than the habit itself. I admit that it might have prevented a small, insignificant number of men from falling victims to the habit. I admit that it might have frightened a number of people into breaking loose from the habit, but it is just as certain that on a very large number of masturbators it had a most disastrous effect.

Much more disastrous, I repeat, than the habit itself. Suppose a boy or young man had read that masturbation meant invariably either an early grave or locomotor ataxia, or general paralysis, or violent insanity. Suppose that in spite of his utmost efforts to break the habit, he was unable to do so. Is it any wonder that such a man actually fell into the condition of hypochondria, became gloomy and morose, lost his appetite and sleep and became a physical and nervous wreck? The doctors then had another example of the terrible effects of masturbation — but it wasn't. The wreckage was simply the result of their distorted descriptions of what masturbation would do.

But it will not do to deny altogether or even to minimize the evil results of masturbation. I studied the subject closely for many years and I have attempted to eliminate various accessory causes, and I have come to the inevitable conclusion that masturbation per se *does* produce very injurious, occasionally even disastrous results. That the results are produced by the masturbation and not by the imagined fears of its evil results, or by the shame and moral degradation, etc., is clearly established by the fact that these same evil results are produced in children who have never heard that the habit is injurious, and who, though instinctively practicing it in solitude, do not in any way feel shamed or degraded by it.

Those who deny any evil results of masturbation might here interpellate the question: Are you sure that those boys and girls in whom you noticed the evil results of masturbation were perfectly healthy and normal before they became addicted to the habit? Are you sure that

they did not have some nervous taint in their constitution before? No, we are not sure. But the question is one of mere casuistry. What is a *perfectly normal* boy or girl? Is there any such thing? Has not everybody some taint in his or her constitution? The fact remains that masturbation produces extremely injurious physical and psychic results in a large number of boys and girls, who, but for that habit, would have remained healthy and uninjured. Further on I give some examples of the evil effects of this habit, where there can be no doubts as to the real etiological factor.

The injurious effects of masturbation are both physical and psychic, and are almost of the same character in both boys and girls, though they are more severe in boys. These symptoms are: anemia, chlorosis, general lassitude and languidness, inability to study or concentrate the mind on any kind of work, weakening of the memory, general loss of self-confidence, avoidance of company, a dragging gait, unwillingness or inability to look people straight in the eye, a pale, dingy complexion with, frequently, pimples and blackheads on the face and dark rings around the eyes. Urinary symptoms are quite common. They express themselves in frequent micturition, dribbling of urine and nocturnal incontinence. While it is true that nocturnal incontinence often *precedes* the masturbatory habit and is probably one of the expressions of a uro-genital neurosis, it is also true that some masturbators begin to wet the bed only after they have indulged in that habit for some time and that nocturnal incontinence is very difficult to cure as long as the habit persists. I have known some young men and women at the age of twenty and

over, who still suffered with that extremely annoying and humiliating affliction, of wetting the bed every night, or almost every night.

The more remote and far-reaching results of this habit are, in men: pollutions, spermatorrhea, impotence, sexual neurasthenia and, the worst of all, complete aversion to the opposite sex. So that they remain either single through life, or if they marry, their wives are unhappy and have to seek relief with other men, or to demand a divorce. The effects in women are also sexual neurasthenia, sexual apathy or frigidity, and complete aversion to or loathing of the male sex. They become completely unsexed. It is they who constitute the saddest and most disagreeable specimens of the sour, crabbed old maid.

And many of them remain old maids even after they are married. For they suffer with *premature ejaculations.* That is they have their orgasm almost immediately on the man's approach, and then they repel the man, unless they have sufficient will-power to conceal their real feelings. The profession is not familiar with the fact that women may also be impotent. They do not indeed suffer with impotentia *coeundi* (except when physically malformed), but they certainly do suffer frequently with ejaculatio praecox; and after the orgasm a further continuance of the act becomes extremely repulsive to many. Many divorces are due to precipitate orgasm in the woman, the result of previous and perhaps still continued masturbation.

A good deal has been written about the changes in the external genitals of women who have been masturbating. I will say right here that in a large percentage of mastur-

bating women — the *larger* percentage — absolutely no signs of any kind can be discovered; no more than any signs can be discovered in masturbating boys and men. Much has been written about the enlarged clitoris in girls who have masturbated. As a general statement I deny it most emphatically. An enlarged, hypertrophied clitoris is found in some masturbators, but only in a small percentage of cases. And then we cannot be sure that the large clitoris did not exist before the girl began to masturbate, and that it was not the *cause of the masturbation*. Masturbation does not cause an enlargement of the penis in boys; why should it cause an enlarged clitoris in girls? It may be somewhat congested and swollen, but congestion and swelling is not hypertrophy; it generally subsides after soothing and cooling compresses. The labia majora and minora may be elongated and thickened, somewhat bluish, or deeply pigmented, almost black; and where the masturbation is practiced excessively, violently, furiously, with the use of the nails or foreign objects, there may be scratch marks, lacerations, scabs and scars. One symptom is quite common: a gaping of the vaginal orifice. In women who have given up the habit, or in cases where the masturbation has been practiced for many years, the hypertrophy of the labia is followed by atrophy.

Krafft-Ebing well says of masturbation that "it strips scent and beauty from the bud, which should unfold to a perfect flower, and leaves behind only the coarse-minded, animal instinct for sexual satisfaction. If such a ruined individual arrives at the procreative age, he lacks the esthetic, ideal, pure, and ingenuous attraction, which attracts to the other sex. The glow of the sensual per-

ceptions is quenched, and the inclination to the other sex is considerably weakened. This defect influences the morality, ethics, character, imagination, mood, feelings and impulses of the youthful masturbator, whether male or female, unfavorably, and in *some cases extinguishes the desire for the other sex entirely*, and causes masturbation to be preferred to any natural sexual intercourse."

The Masturbator's Face. In former years we used to hear and read a good deal about the masturbator's face. The "literature" of the out and out quacks and semi-quacks who make their living by scaring people, still has a good deal to say about it. It is asserted that the masturbator's face is distinct and peculiar, and the solitary vice can be read as clearly there as in an open book. This is all bosh. When a masturbator thinks that this is the case, then he may by his self-conscious conduct, by a certain shyness and timidity, give himself away. In excessive masturbators, the symptoms of a general run-down condition may be clearly evident. The black rings around the eyes, in girls particularly, often tell an unmistakable tale. But not any more so than in patients suffering with pollutions and spermatorrhea or indulging in excessive intercourse. And a large number of masturbators appear pictures of perfect health, and there is not a trace of anything in their faces to betray their habit.

This is important, because the only trouble some masturbators experience is the fear that people can see in [their] faces what the matter with them is. If assured that [this] is not the case, that there is absolutely nothing in [their] face to betray them, their trouble disappears and [they f]eel easy and content.

Masturbation Shreds. The experienced physician will often diagnose masturbation with certainty from a mere examination of the urine. The urine of the confirmed and excessive masturbator often contains numerous small fine shreds. They differ from gonorrheal shreds in that they are much shorter — ½ to ⅛ inch long — are quite thin, have no tendency to curl or roll up, and are free from gonococci. These shreds betoken an inflammation of the posterior urethra and are present only in those masturbators who have practiced the habit to excess, or in a protracted manner, etc. These shreds may be present in any condition of prolonged sexual excitation without gratification.

As to the question whether masturbation may give rise to an organic cicatricial stricture, I should not wish to be dogmatic even here. I have seen strictures in young men who had never had any venereal disease, and where masturbation *seemed* to be the only etiologic factor (of course they could have been congenital). There is no reason why a low grade inflammation kept up for years may not give rise to cicatricial changes. Still, well authenticated cases of organic stricture with masturbation as the sole cause must be very few in number. It is also well to bear in mind that a somewhat inflamed urethra furnishes a favorable soil for micro-organisms, and that the urethra of the excessive masturbator is more vulnerable and therefore more prone to bacterial infection of various kinds.

CHAPTER FOUR

THE PROPHYLAXIS OF MASTURBATION

The Prophylaxis of Masturbation. If the adage "an ounce of prevention is worth a pound of cure" is true of any disease or habit, it is true of masturbation. One could say that the best and most effective cure of masturbation consists in preventing it.

In considering the prevention of masturbation we must really consider the entire subject of the bringing up of the child. In fact we ought to go still further and consider the child's heredity — its parents. For strongly neurotic parents very often mean a neurotic condition in the child and a neurotic condition is often the strongest predisposing factor in masturbation. But as we cannot change the child's parents, we must try to see what we can do with the child itself.

The keynote of prevention consists in careful watching of the child and watching it from its earliest infancy. We know that not infrequently stupid or vicious nursemaids, wet nurses, and even governesses ignorantly or deliberately induce the habit in children under their charge. This must of course be prevented. Even children of the age of nine, ten, eleven should never be left alone without any supervision. Too close friendship between boys or girls, particularly of different ages, should be looked upon with suspicion. Boys of fourteen, fifteen or sixteen do not, as a rule, make good companions for boys of

ten or eleven. Several boys or girls should never sleep in the same room without supervision by an older person.

The sleeping of two in the same bed whether it be the sleeping of two children or the sleeping of an adult and child should under no circumstances be permitted. I admit of no exceptions to this statement. It makes no difference whether the other person is a mother, a father, a brother or a sister. Leaving any *deliberate* element out of the question, the thing is dangerous, for very often unintentional, unwitting masturbation is initiated thereby.

The child, boy or girl, should sleep alone on a rather hard mattress. The covering should be light. A coverlet may be put over the feet. The child should always sleep with the arms, *not under,* but *on* the cover or blanket. If this is done from childhood, it is very easy to get used to this way of sleeping and many cases of masturbation are avoided thereby. The child should not be permitted to loll in bed. It must be taught to get out of bed as soon as it wakes. The general bringing up must be of a strengthening, hardening character and this applies both to body and will. But I will not go deeper into this part of the subject as this comprises the general subject of education. Nor will I deal with the subject of sexual enlightenment of the child, because that is also a subject in itself. I will merely state here, that when a child reaches the age of nine, ten, eleven, twelve or thirteen (we must use discrimination and judgment, for some children of nine are as developed as others of thirteen), we must tell them that it is bad and injurious to handle one's genitals, and we must warn them to shun any companions who wish to initiate them into any manipulations of the

genitals, or who show a tendency to talk about the sexual organs and sex matters.

I would say that hot baths are very injurious for young children in this respect. There is no question that a hot bath has a very decided stimulating effect on the sexual desire of both adults and children, male and female, and I have had several patients of both sexes tell me that their first masturbatory act was committed while in a hot bath. And of course the sensation having been very pleasant they kept on repeating it.

One little point about boys' clothes. Their trousers should be made without pockets, for boys often begin masturbation by fiddling about with their hands in their pockets, and masturbation is very frequently performed through the pockets. They will often make a hole in the lining for that purpose.

Other points in prophylaxis will suggest themselves. Any factors which, in considering the etiology of masturbation, we saw are apt to cause the habit, should naturally be removed. Thus for instance phimosis, eczema about the genitals, strongly acid urine, seatworms, etc., should be treated and removed.

That anything which has a tendency prematurely to awaken the sexual instinct should be rigorously avoided goes without saying. Musical comedies and certain vaudeville shows exert a pernicious influence in this respect. I do not demand any censorship over our theater, but I am simply stating facts. Many of my patients told me that their first masturbatory act took place while witnessing some musical show. Libertarian that I am, I would nevertheless strongly urge parents to keep their boys away from sensuous musical comedies and obscene vaudeville acts.

CHAPTER FIVE

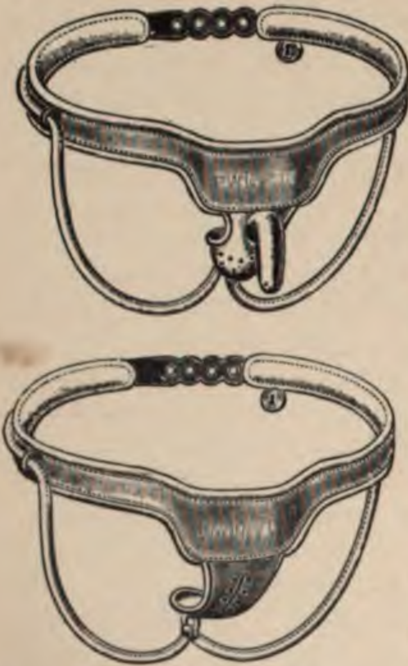
THE TREATMENT OF MASTURBATION

The Treatment of Masturbation. In the treatment of masturbation, points of the first importance to consider are the age of the patient, his or her general physical and mental make-up, the *degree* of the addiction to the habit, and the presence or absence of any local causative conditions.

Masturbation in Children. Masturbation in infancy and early childhood forms a chapter in itself. Here the treatment is chiefly prohibitive and punitive. You cannot reason and argue, and explain the injuriousness and the "sinfulness" of the habit to a boy or girl of three or six or nine. You must simply watch them, prevent them from indulging in it, and punish them sharply if they are caught at it. I believe that with children, to whom reasoning and moral suasion make no appeal, physical punishment is the only alternative and is morally fully justifiable. Only there must be no spanking, for spanking has a distinctly sexually exciting effect on many children. While the nates are the most sensitive part in this respect, any part of the body may be responsive. And some children, as has been found out, will deliberately do certain mischievous, forbidden things, in order to be spanked, because the spanking causes them sexual excitation and satisfaction.

As stated in the chapter on Prophylaxis, boys' trousers

should have no pockets. The masturbating child's arms should be put in long sleeves, which should be so pinned or tied, that the child's hands could not reach the genitals. In some cases, it is also necessary to put on long drawers, buttoning in back, and spread the legs apart attaching them to the bedclothes or the bedpost, so that one thigh cannot be rubbed against the other. There are also specially made appliances of metal, made differently for male and female children, which are put on over the genitals, and protect them so that the child cannot handle them (see illustrations).



In two or three cases I have found it necessary to apply rapidly a red hot wire to the child's genitals, to the prepuce in a boy, to the labia majora in a little girl. Whether because it was too painful to handle the parts, or because the shock of the application made a strong impression, or whether it was the fear of a repetition of the same treatment, but this little rather brutal procedure proved effective: the child ceased to masturbate.

It should not be necessary to state it, but nevertheless it must be mentioned as a reminder, that wherever there is a local cause, which is supposed to be responsible for the masturbation, it must be removed. A phimosis must be treated, and complete circumcision is sometimes very beneficial; an adherent clitoris must be freed; seatworms must be banished at once with santonin, chenopodium, or rectal injections of salt and quassia. Eczema or any other dermatosis of or about the genitals must be cured in the promptest possible manner.

Psychic Treatment. When an adult — say from thirteen on — comes or is brought to us, we must first of all size up our patient. If he is unaware of the possible grave results of the habit, or if having heard of such results he is skeptical about them and is inclined to make light of them (we come across such patients too), then it becomes our duty to impress upon the patient's mind the seriousness of the habit and the possible very dangerous, life-long consequences. The possibility of impotence must be presented to him, and this generally has a deterrent effect. But we must guard against senseless exaggerations. For they are apt to miss their object entirely, and by making the patients lose confidence in our statements, may do more harm than good. When the results of masturbation are painted in too lurid colors, the effect may also prove contrary to what we expect, on account of the depressing influence on the patient's mind. He may imagine that he is irretrievably lost anyhow, and that it is therefore useless to make any attempts at reform.

When on the other hand we find the patient deeply affected and humiliated by his habit, when we find that he

has stuffed himself with the damnable quack and semi-quack "literature," which pictures the most moderate indulgence in masturbation as the vilest of crimes, the deadliest of sins, the most injurious of habits, leading inevitably to paralysis and insanity, when we find that the patient considers himself as one of the vilest wretches. the lowest of sinners, unfit to go among decent men (we have seen just such types), then it becomes our duty to strike an entirely different tone. It is sometimes even necessary to go slightly to the other extreme. We have to tell him that there is nothing criminal, sinful or vicious in the habit per se, that it is a vice merely in the sense in which every habit which weakens the body and the mind is a vice, for instance like alcoholic indulgence is, no more, no less; we have to explain that if everybody who ever indulged in masturbation was to be considered a criminal, then practically all mankind was so to be regarded, because about 95 per cent of all males have masturbated at one time or another. We also have to explain that the injuriousness of masturbation lies not so much in the habit itself, but in the excessive indulgence in it. We have to explain to him that not everybody who practices the habit is invariably injured by it. Tens of thousands of men who practiced it in early youth and have given up the habit are in perfect health now. It all depends upon the person's constitution, the age at which he started, the frequency of the indulgence, etc. It is remarkable what a good effect such talk has on this class of people. They leave the office different men. They become imbued with a new hope, a new determination to conquer the habit. Their self-respect is increased, their will-power is strength-

ened, and with a little additional help from the doctor, they often succeed in restraining themselves, where they failed before. And a few successes in this direction tend to still further strengthen their self-respect and will-power, and very frequently a timid, shambling, self-contemptuous masturbator is converted into a strong, self-confident man in the short period of two or three months.

I remember one patient, as perfect a specimen of manhood externally, outside of his sexual organs, as one wants to see. His physical health was not in the least impaired by the habit. No neurasthenic symptoms of any kind. And nevertheless that man suffered tortures, because he had read that there were certain peculiarities in every masturbator's face, by which the habit could be diagnosticated without fail. And he feared that everybody or almost everybody knew that he was a masturbator. When I assured him that it was all rot, that there was no such a *facies* except in extreme cases of debilitated youths, that he looked the picture of health, and that with the strongest magnifying glass no telltale marks could be discovered in his face, he heaved a tremendous sigh of relief. "You have lifted a great burden from my head," he said (a very common expression). And his improvement was continuous from that time on.

Medicinal and Other Treatment. Psychic or psychic-suggestive treatment is important, but not all sufficient. Having put ourself into the proper relation to the patient, having gained his entire confidence, and having secured for him the right perspective of his condition, we proceed with the other adjuvant treatment.

Medicinal treatment can seldom be altogether dispensed

with. It is a great help. Among drugs the bromides play here an important rôle. I have expressed myself elsewhere (see chapters on Pollutions and Spermatorrhea) about the pernicious effects of the bromides, particularly if given in too large doses, for too long a period. I know all their dangers and unpleasant by-effects. But, nevertheless, in masturbation we are often unable to do without them, and I prescribe them on the principle of choosing the lesser of two evils. Most patients do not possess sufficient will-power to break themselves of the habit, without any extraneous aid. If they did they would not have to go to the doctor (and those who do possess it don't go). And so we must help them. And the bromides are such a help. By depressing the libido sexualis, by soothing the general nervous irritability, by inducing or improving the sleep, they make it easier for the patient to resist any desire to masturbate. And as masturbation is to a great extent a habit, if the patient succeeds in not indulging in it for some time, it becomes easy for him to break himself of it altogether. But of course the bromides must be given with care and judgment. Given in too large doses and for too long periods without interruption, they may completely and permanently extinguish the sexual desire, and the ability to have erections. As to the size of the doses and the choice of the bromides the physician must judge for himself. The potassium bromide is the most effective, but also the most injurious. The bromides of strontium and sodium are the best. It is often necessary to give sixty grains of the combined bromides per dose, three times a day. With improvement in the condition, i.e. when the patient tells us that his erections are not so frequent, and

that his desire to masturbate has diminished considerably, the size and frequency of the doses are to be reduced. It is always best to give the bromides in some digestive vehicle, such as essence of pepsin, peptenzyme, lactopeptin. (See last chapter for prescriptions.) There is no question that if so administered the bromides are much better borne: there is less digestive disturbance, less liability to bromic acne and even less depression.

I have found the administration of adrenal substance useful in conjunction with the bromides; the adrenal has a tonic effect and counteracts the depressing effect of the bromides.

Another substance that I have been administering with signal effect in some cases is thyroid extract. It is my belief that the extreme or so-called furious masturbators suffer with some thyroid deficiency. This affects their mentality and will-power. The thyroid has a good effect on their general metabolism and on their mentality. Of course the thyroid must be administered with discrimination, and the effects must be carefully watched. I have also lately administered pituitary extract and pituitrin with what seemed to be good results, but I have not administered it in a sufficiently large number of cases, to justify me in pronouncing a definite opinion.

Small doses of atropine (1-500 to 1-200 grain) also seemed to me useful in diminishing posterior urethral and vesical irritability. As masturbation and nocturnal incontinence of urine go so frequently together, and as atropine is so useful in the latter, I thought it might also prove useful in the former; and it apparently does. Small doses of tincture of iron with still smaller doses of tincture of

cantharides (Tr. Ferri Chloridi ʒ vi, Tr. Cantharidis ʒ i, two to seven drops according to age in a little water, or lemon syrup, ter in die) have also proved useful in my hands.

Hydrotherapy. Among other measures in the treatment of masturbation, hydrotherapy plays an important part. Cold rubbings, cold spongings, cold douches to the back, cold dips, do excellent service in strengthening both the physique and the will-power. Care must be taken of course that the skin reacts properly after each hydrotherapeutic procedure. Local ablutions of the genitals are best avoided, as the subsequent drying of the parts may act as a stimulus to masturbation. The use of cold urethral and rectal psychrophores by the physician (see the chapters on Pollutions and Spermatorrhea) is sometimes very beneficial.

CHAPTER SIX

MARRIAGE AND MASTURBATION

Let us assume that we have to deal with a young man of twenty, twenty-two, or twenty-five, who is strongly sexual. We have used all the means at our command, he has coöperated with us, and used all his will-power to break himself from the habit. And he has succeeded *in a way*. That is, while before he was in the habit of masturbating every day, or twice a week, he has now restrained himself for nearly two months. But this restraint has cost him a terrific struggle and he had to use up an immense amount of energy. He was unable to attend to his studies as well as he should, he was irritable and he slept poorly, but he triumphed over his habit, and he felt rewarded. One evening, however, he does not know how it happened, he fought hard enough against it, but it happened; and he then indulged in it again excessively for two or three weeks. Again treatment; again abstinence for a longer time, and then again a "fall." And it is becoming more and more difficult for him to devote himself to any mental work. Or the case may be somewhat different. By the expenditure of a tremendous amount of nerve force, aided by the bromides and other measures, our patient has succeeded in overcoming his habit. But he finds to his consternation, that he is now having pollutions, they are becoming more and more frequent, and they are weakening him terribly.

In other words, what are we to do in the case of patients who are so strongly sexed, that, with the best will and with the best treatment, they cannot break themselves of the habit, except for a short time only, or who begin to suffer with such frequent pollutions, that we have a right to fear for their sexual power?

In such cases it becomes our duty to advise our patients regular sexual relations. If we are sure that their sexual power is not impaired and if other conditions permit, we may advise marriage. But, while I shall have the opportunity to discuss this point in a later chapter at greater detail, I cannot refrain from stating here, that this thoughtless advice to get married is responsible for a great deal of misery and that members of our profession have a good deal to answer for in this respect. To advise a confirmed masturbator to get married without being sure of the integrity of his sexual potency and without his having given proof that he can break himself of the habit at least temporarily is nothing short of criminal. For marriage is not in every instance a cure for masturbation. There are plenty of cases of married people, who keep up the habit *even though indulging in regular sexual relations;* and there are others, who have a dislike, a loathing for regular intercourse, neglect their wives, and continue the habit with undiminished persistence; and the same is true of women who are confirmed masturbators. They often loath their husbands, dislike sexual relations and remain slaves of their old habits. It is therefore more honest, more decent, more honorable, more moral, to advise a masturbator to attempt first illicit relations; if he finds that his sexual

power is good, that while satisfying his sexual desires normally he has no desire for masturbation, then it is safe for him to get married. If on the other hand he finds that his erections are weak, his ejaculations precipitate or premature, or what is perhaps sadder still, that normal intercourse does not satisfy him, and that his longing for his old habit remains undiminished, then no harm has been done to anybody, the man knows that he is not in a fit condition to marry, and that he must treat himself, and treat himself, until by another trial he has found that his condition has become changed.

Marriage has been too thoughtlessly recommended as a cure for masturbation, for pollutions, for spermatorrhea, even for a lack of libido and for homosexuality. This was due to the general ignorance of the profession in matters sexual. Let us hope that all those who study this book will be more careful in the future, and will not dispense the matrimonial advice thoughtlessly and indiscriminately.

If I write on this subject so frequently and so emphatically, it is because I know the inside histories of too many unhappy homes. "Get married." And he gets married and he finds either that he is unable to perform the sexual act at all; or if he performs it, that it does not satisfy him. And he curses the physician for his advice. And I state it as my positive opinion that the ignorance of our profession of the physiology, pathology and psychology of the sex instinct, and the careless, thoughtless counsel so often given without any consideration of the possible consequences, is responsible *more than anything else* for the contempt in which the medical profession is held by a large number of

the laity, and for the alarming antagonism to it in many quarters. Thoughtless advice to a confirmed masturbator or to an impotent to get married may result in the *life-long* unhappiness of two individuals.

CHAPTER SEVEN

MASTURBATION, LOCOMOTOR ATAXIA AND INSANITY

Syphilis is now so universally accepted as the sole etiological factor in locomotor ataxia, that to suggest any other possible etiology is considered unscientific and unorthodox. That syphilis is by far the most important cause of locomotor ataxia, more important than all other causes combined, I fully admit. But I deny that it is the *sole* factor, and it seems to me, that they who deny the *possibility* of *any other* factor are the ones that are unscientific. I have had, we have all had, a number of cases of patients who absolutely deny any venereal history, and in whom no symptoms of venereal disease could be found, but as they have exposed themselves to the possibility of venereal infection, there is always a legitimate excuse for doubt. One can always say, perhaps the patient had the disease, but it was so slight and it ran such a mild course, the external manifestations of it being so trifling, that they overlooked it. And as the Wassermann reaction was not in use several years ago, we could not positively take the word of those who asserted that they were not syphilitic.

But I have had in my practice three cases in whom any possibility of infection is excluded. For the men never had any sexual relations of any kind whatever. The only etiology which I could discover, and which they themselves gave, was excessive masturbation. One was in an

advanced stage of locomotor ataxia, the other two were in the initial stages. Here the believer in syphilis as the sole cause of locomotor ataxia might object, that it is possible that those patients had a hereditary taint, that they suffered from hereditary syphilis; but repeated Wassermann reactions were negative; their parents were apparently perfectly well, and none of their brothers and sisters showed any signs of either syphilis or of locomotor ataxia.

I therefore stand by my opinion, that excessive masturbation alone, without any syphilis, may *occasionally* be the cause of locomotor ataxia. That in the presence of syphilis it may act as an exciting, accelerating cause, goes without saying. That those three patients to whom I have just referred were nervous or neurotic from childhood, I will admit, and that it is possible that in "perfectly" healthy and "normal" people, masturbation alone will not cause locomotor ataxia, I will also admit. But, as I have said elsewhere, a "perfectly" normal individual is an *avis rara,* and we never know who has and who has not some taint in him or her.

The point of practical importance remains that masturbation alone, without syphilis, may in certain individuals be the cause of locomotor ataxia.

Can masturbation lead to insanity? This question is touched upon in chapter nine, among the case reports, to which the reader is referred.

CHAPTER EIGHT

REPORTS OF CASES

It is my intention to present in each part of the book a number of cases from actual practice, giving their etiology, symptomatology and actual treatment. Actual cases always leave a more vivid and more lasting impression than abstract descriptions. And many points which were either left out or only alluded to in the other chapters will be touched upon in the reports of the cases. It is therefore just as important to read and analyze the case reports as it is the rest of the text.

Case 1. I put down this case first, not because it presents any unique features, but for the reason that chronologically it is the *last*. I saw this patient only this morning (November 28, 1912). He was sent to me by Dr. Herman Cohen of this city. He claims to have masturbated from his earliest infancy. Even when in the cradle he would rub his thighs, or handle the genitals. His mother saw it, but being an ignorant woman she did not think there was anything wrong or injurious in it. His various motions simply seemed to her funny — all this he learned from her later on. Whether he masturbated between the ages of two and seven he doesn't distinctly remember. He thinks he did. But from the age of seven he masturbated right on without any interruption up to two weeks ago, *when he got married.* He is now 28 years old. He masturbated regularly from three to seven times

a week. Sometimes even more than once a day. To the question, didn't he know that it was injurious, he said he heard it was a bad habit, but as it didn't *seem* to hurt him, and as he was so used to it, he didn't make even an attempt to give it up. At first he would get an erection during masturbation, but during the last 6–8 years, no erection would take place and the ejaculation would take place in the flaccid condition. He masturbated up to the day he got married, but for the last two weeks he has abstained. That is, he thinks he has. He attempted intercourse every night, but though he could get absolutely no erection, he would have an ejaculation. Naturally, under these circumstances he could abstain from masturbation. I asked him if the question did not at all present itself to him, that he might be impotent, and he answered in an emphatic *negative. He did not know that there was such a thing as sexual impotence.* He thought that every man when he got married was all right. I have not mentioned it, but it is self understood that this patient never attempted intercourse until his wedding night. In former years I would have doubted the fellow's sincerity, as to his belief that every man was all right, but I had had several patients, who were the most astonished persons after their wedding night, who assured me earnestly that they never heard that men could be "no good" for marital duties, any more than women could be "no good." The density of the ignorance on sexual subjects among the people is something appalling. And since I have had physician-patients who showed the same ignorance I have ceased wondering at anything.

Examination showed a pale, extremely anemic, some-

what jaundiced undernourished individual, with weak and irregular pulse, with the genital organs undersized and cold, with the prostate hypersensitive and the prostatic urethra *exquisitely* tender and painful. The mere gentle passing of a small bougie à boule caused him to faint away, and it was an hour before he could leave the office. When I told him that it might take months of painstaking treatment before he would regain his virility, and that it was also possible, that he would never regain it, he broke out into sobs, and blubbered like a child — or a fool. What bothered him most was that his wife was still a virgin. If only not that, he would be satisfied. For this way, *i. e.,* her being a virgin, he cannot even consider her his wife. Among the lower classes it seems a *disgrace,* and not a misfortune, for a married woman to remain a virgin. What fools these mortals be.

In this case the causative relationship between the masturbation and the impotence, which I fear will be permanent, is quite clear. There is no other etiology.

[*During proofreading Jan.* 17, 1913]. Just as in practice apparently trifling cases sometimes prove extremely obstinate and recalcitrant to treatment, so we sometimes have surprises the other way. Patients whom we thought hardly amenable to treatment occasionally gratify us by the remarkably rapid progress and improvement which they show. If it were not for these occasional pleasant surprises the practice of medicine would be a sorry vocation.

The case just reported is an illustration in point. I had very little hope of the patient's improvement and so wrote to the doctor, and in fact told the patient that I

would much prefer not to treat him. But he begged and entreated and said that my refusal to treat him would be equivalent to a death sentence, so I undertook his treatment; and he has been making unexpectedly rapid progress. The treatment was at first general, consisting of organic preparations of iron, glycerophosphates, strychnine, alternate warm and cool baths. The local treatment consisted in passing a psychrophore (through which hot water and then cold water was passed) through the previously anesthetized urethra. The attempt to pass a psychrophore without anesthetizing the urethra again resulted in a fainting spell.

He has been but seven weeks under treatment. His general health has improved, he has gained weight, feels stronger, and what is more important, he has succeeded in having an erection with penetration. For the first four weeks of the treatment he abstained entirely. From the way things look now, this patient may be brought to a fair degree of sexual vigor.

[Additional note for the second edition. April 13, 1913.] The man's improvement has been uninterrupted. His wife is now in the fourth month of pregnancy, and he performs the sexual act to his and her perfect satisfaction. He tells me that if I gave him permission he would indulge every night. He feels himself capable of doing it.

After all we physicians do some good. We cannot convert all weaklings into Herculeses, but if we convert a certain number of impotents, to whom life is a torture and a burden, into normal human beings capable of enjoying life, then our existence is justified.

Case 2. Physician, 32 years old, from South Carolina,

chrophore and bathing the genitals with cold water, improved the condition so that he was able to perform *satisfactory* intercourse once. An attempt the second time, on the night following failed, however. The treatment was continued, the colliculus seminalis was cauterized, and he was again able to perform the act satisfactorily. He is now continuing the treatment on himself as well as he can, and he writes me that he can have satisfactory relations once a week or once in ten days. Not oftener. I wrote him to be satisfied and not to overexert himself. I am sure that with proper care he will be all right for good. in fact, he may gradually gain in sexual strength. I have seen many such cases.

[Note to second edition.] A letter received from him a few days ago informs me that everything is highly satisfactory to both parties.

Case 3. This case was referred to in the section on the frequency of masturbation. It was not necessary to use any moral suasion with this patient. He was an intelligent young man of 26, and he was as anxious to get rid of the habit as one could well be. He said he would use his utmost will power, but he wanted some additional aid.

I gave him a mixture of the bromides of potassium, sodium and strontium, which contained 60 grains of the combined bromides to the dose. I told him to start taking the medicine about a week before the expected onset of the attack — 60 grains four times a day — and if he felt the attack coming on irresistibly, to take a dose *every hour*. It was a powerful dose to give, but I knew that in such cases we could expect results from heroic doses

only. I cauterized the colliculus seminalis, which was extremely inflamed and bled at the least touch, and gave him a few drops of strong nitric acid and a glass rod, with instructions to touch the glans and the dorsum penis, when he felt that resistance otherwise was no longer possible. I explained to him just what the acid would do, the caution necessary in using it, etc. It was an interval of nine weeks before he began to feel the resistless desire stirring within him. He began to take the hourly doses, which he continued for a day, and then he felt no desire for two weeks more. He awoke one night with an irresistible desire, masturbated twice, and then only got up, applied the acid, and began to take the medicine. He took the medicine for a week, four times a day, and was free from any desire for nearly three months. Then he "fell" again. I once more cauterized his colliculus seminalis, he took the bromides regularly three times a day, and not only did he abstain from the habit altogether, he had no desire to indulge in it. I fear that his libido and potency have been somewhat affected by the bromides, but there was no way out. I had to take some chances, and it was absolutely necessary to break up a habit, which had something epileptic about it, so helpless was he, when the desire came on.

Case 4. Girl of seven. Bright, intelligent, very clever in her studies, but masturbates furiously, at every possible opportunity. In spite of the most careful watching, in spite of being frequently whipped she indulges in the habit several times a day. She will sometimes do it, though cautiously, even in the presence of others. According to the mother, she has been getting worse in this respect for the

last three months, and to this she ascribed her extreme paleness and anemia. The clitoris was found to be red and raw; there were also some raw scratch wounds on the labia majora and minora, as if the nails had been used. I cauterized the clitoris with solid silver nitrate, and the raw spots I touched with a *red hot* iron wire; I also touched the back lightly with the wire. The pain was excruciating, but I considered that the only proper method. It was necessary to make a strong physical and psychic impression. The child was also told, that she would have to undergo the same treatment every day, unless she refrained absolutely from masturbation. The mother was also told to watch her carefully for a few days. A soothing ointment consisting of morphine, cocaine, zinc oxide, bismuth subnitrate, phenol, vaselin and lanolin was ordered to be applied to the vulva three times a day. *The child gave up the habit entirely.* Once or twice, it was noticed, she attempted to manipulate the organs, but, apparently on account of the pain, she desisted at once. Two months later she again fell into the habit, but she practiced it to a much lesser degree. She was brought again to my office, but she promised that she would never do it again, and she kept her word, so that I did not have to repeat the cauterization. It is also interesting to add that this little patient was suffering with frequent nocturnal enuresis, and the treatment cured her not only of the masturbation but of the enuresis as well.

Case 5. No age is exempt from masturbation. The previous case was of a girl of seven. This case report deals with a man of seventy and possesses several curious

features.* It shows how persistent and obtrusive the sex instinct often remains, even after the advent of complete impotence. The patient is aged seventy, perfectly rational, married for the last 48 years; his wife is still alive and they are living together. He has several married children, the oldest being 45 years of age. He is a sufferer from rheumatism and a victim of spermatorrhea. Sexually he has been impotent for many years. He looks emaciated, anemic, and listless.

He has not had a proper erection for the last 10 years. He frequently practices masturbation and feels a peculiar satisfaction in doing that. Of late he discovered that when he puts his finger in the rectum and keeps on "rubbing," as he expresses it, he succeeds in getting the penis properly erected and ejaculation is more satisfactory. This mode of exciting his genital organ gave him entire satisfaction for many months. One morning he felt that he must "excite" himself. He "rubbed and rubbed" the rectum but, this time, could not get the least erection. He tried over and over again, but to no avail. Being strongly excited and laboring under a peculiar nervous impulse, he got hold of a broom-stick, sawed off a long piece of it, greased it with some fat and forced it into the rectum, pushing it higher and higher up. This had the desired effect and, he says, he enjoyed it immensely. But at this point, at the acme of excitement, his entire body was shaking, his hands trembling, and in another second the greasy stick was all in the rectum and slipped from his fingers.

After regaining his self-possession, he thought he could

* American Journal of Urology, January, 1908.

easily get it out by straining a little at stool. That day he went to toilet a number of times, straining with all his might until blood showed and the rectum prolapsed; but the stick failed to come out.

At 9 P. M. he retired an exhausted man. He slept at intervals only. He was up early on the next day and renewed his visits to the toilet, straining even more forcibly than the previous day; but to no avail. Worried, anxious, fatigued, and disappointed, he again retired for the night. He slept for the first 2 or 3 hours; the rest of the night he was restless and planning how to get rid of the stick. He at last found hope in one thought: namely, if he had a pair of forceps he, most probably, could pull it out. He got up early in the morning and obtained a pair of rusty large forceps. He took a hot bath with the hope that this would facilitate matters and began his work with the forceps. At first he was a little careful; but soon became desperate and began to manipulate the instrument wildly; he neither cared for the pain he caused himself by repeatedly pulling on the mucous membrane of the rectum, nor for the blood that was now freely oozing. After considerable torture and disappointed work, he grew faint and exhausted. At last, after having the stick in the rectum for two days, he decided to consult a doctor.

He was hardly able to walk; but he managed to drag himself to the office. In painful words he recited the history of the case and begged, with tears in his eyes, to keep the matter away from his children so that they may not learn of this shameful act of his.

Examination.— Inserting the index finger into the rec-

tum, the thick and rough end of the stick could be felt. The mucous membrane was red, the sphincter relaxed and the rectum prolapsed.

Straining brought the end of the stick only as far as the tip of the coccyx and no more.

After some pretty hard work and without any anesthetic the stick was extracted. It was covered with fecal matter and blood and mucus. It measured 7½ inches in length and 1⅜ inches in diameter.

In the *American Journal of Urology*, May, 1913, Dr. John O. Rush reports the removal of a mass of chewing gum from a man's bladder. The man rolled up the chewing gum in the form of a long stick which he introduced into his urethra to relieve a "tickling." It slipped beyond the cut-off muscle and got into the bladder, from where it had to be removed by operation.

CHAPTER NINE

CAN MASTURBATION EVER LEAD TO INSANITY?

I will touch upon this question in next case report.

Case 6. This is the severest case of the evil results of masturbation that I have seen in my own practice.

A young man, 24 years of age, was "brought in" by his two brothers, one older than himself, one younger. I say "brought in," because though he was well able to walk, he did not want to come in. It took a good deal of urging, intimidation and the use of some force to bring him uptown. And when he was in the parlor, it took quite some additional urging to make him come in the office.

The brothers told me the history. Up to the age of eleven or twelve, he seemed to be as normal as the other children. Then he began to fall back in school, so that after being left three or four times in the last grade of grammar school, he had to leave without graduating. At the same time he became gloomy, taciturn, irritable, occasionally snarling. They knew that he was masturbating —"like all boys"— but since he was 16 or 17 he began to practice the habit excessively and the last few years he had no hesitation in practicing it even in the presence of others. His intelligence was getting lower all the time. At first he kept some positions, as boy in a drug store, then as junior drug clerk — the brothers were both druggists,— but gradually a drug store position was too much for him, and he took a position in a grocery store. The

last year or two he did nothing — just stayed around home, where he would sit listlessly about for hours at a time, going out on errands and obeying orders occasionally, but occasionally refusing to move from his room for days. He sulkily obeyed my order to undress, but when he found that my object was to examine him, he rushed into a corner, and began to fight his brothers, who wanted to bring him to the examining table. He became so agitated and wild that the attempt to examine him had to be given up.

I learned from the brothers that all other children were perfectly normal, that the parents were normal, but that their mother's father was "queer," and that an uncle was in an asylum. This case brings up the interesting and mooted question: Did this young man become insane (we will call him insane, for if he was not yet quite insane, he was surely on the way to insanity) on account of his excessive masturbation, or did he masturbate excessively because the taint of nervous instability was in him? It is absolutely impossible to answer this question dogmatically. One could retort that the other brothers did not masturbate (or only in moderation) and they remained sane. But how can we prove, that they also had the same neurotic taint in them? They had the same heredity, but that does not mean that they all inherited the same taint.

The most conservative statement that can be made is this: Masturbation alone will probably never lead to insanity; there must be an underlying cause, a neurotic taint, a germ of insanity. That the masturbation acts as an exciting cause, bringing about insanity, which might not otherwise have occurred, cannot be a subject of much doubt. Here is another point for casuists and hair-splitters to

discuss. Some maintain that if perfectly "untainted" human beings were to indulge as excessively in masturbation as the "tainted" boys and girls do they would also go insane. The reason they do not go insane is because they do not indulge so excessively; and the reason they do not indulge so excessively is because they are sane and rational. And so here we are, turning in a circle.

CHAPTER TEN

THE ALLEGED HARMLESSNESS OF MASTURBATION

On no sexual disorder is there such a diversity of opinions as on masturbation. There is no difference of opinion as to the pathological significance, for instance, of nocturnal pollutions or spermatorrhea. There is, however, a very wide difference of opinion as to the injuriousness of masturbation, and while I belong to those who strongly believe in the evil (possible though not inevitable) results of masturbation, it is my duty to state that some investigators deny utterly the injurious effects of the habit.

I am sure that they are wrong, that their experience has been deficient, or their observation insufficient, but I do not wish to give the impression that there is a unanimity of opinion on this question, and it is therefore my duty to refer to the other side.

One of the best articles denying the injuriousness of masturbation is a paper by Dr. A. C. McClanahan, which appeared in the *New York Medical Journal* for October 9, 1897. He reports a number of cases in which masturbation apparently did not prove injurious. I will reproduce here two of the most significant ones:

Case 1. "A. P. began masturbating when he was only ten or eleven years old, and in a few months was so addicted to the habit that he practiced it nearly every night, and continued to do so without cessation till he was mar-

ried at the age of twenty-four. After getting warm in bed, he would almost invariably masturbate, after which he would promptly fall asleep, and sleep till morning. During all of this time he lived on a farm. He was always active and industrious, and as he grew to manhood one of the hardest workers I have ever known. He attained a height of five feet, ten inches, a weight of one hundred and sixty-five pounds; his muscular development was fine, and is at present. He was never confined to the house by sickness after his early childhood. His mental development was not equal to his physical, yet he was a faithful student at the country school which he attended in winter. He was superior to most of his class in arithmetic and algebra, and also in grammar; was a fair reader, and an abominable speller. Until he was fifteen or sixteen years old he was as cheerful as any country boy, but at this time a book treating of the sexual organs and functions fell into his hands through the medium of soliciting agents. This book, like the rest of its kind, was only fit to be burned. The hideous fate of the masturbators as described in this book made a profound impression on A. P., and he tried to break off the habit; he learned, however, that he was powerless to do so, and from this time forward he was less cheerful, markedly irritable, and was called a grumbler; but he was no less active or industrious, and no more tolerant of laziness in others. He is still an industrious farmer, is the father of three bright children, and has lived happily with his wife ever since he married her ten years ago. If size is an evidence of vigor, his generative organs must be remarkably vigorous, for, even after the most protracted abuse, his erect organ measured

seven inches along the dorsum from pubes to glans. Nor had he any decline in sexual desire."

The second case is as follows:

Case 2. "D. E., aged fifty years, about five feet eight inches tall. Refined in appearance and agreeable in manner. During the whole period of adolescence and early manhood he masturbated habitually, usually several times a week, and often several times in one night. His parents learned of his habit, and, with the kindest intentions, did more harm than good by their efforts to stop it. The consequences of self-abuse were pictured to the boy in the most appalling colors. His soul recoiled in horror from the fate that was said to be in store for him unless he discontinued his habit, nay, he was made to believe that his filthy habit had already rendered him unfit for human companionship. In one moment of despair the light of his life went out. Henceforth his most resolute and continuous efforts were directed to the conquering of his habit, but he would grow weary of the gloomy struggle; from sheer exhaustion his vigilance would relax; and the pruriency of his nature, which had apparently only been husbanded by repression, would break forth with an imperiousness which he was powerless to resist. A wave of passion would sweep over him, which, gathering fury with its progress, would make his blood boil and seethe with sensuality till the complete act of masturbation had given him relief. Then he was plunged into the depths of despair and degradation till the inevitable temptation came again. Feeling its approach, he would kneel at his bedside, and, with tears streaming down his face and sobs breaking his voice, would pray to God to help him overcome his hideous

habit; and he would then go to bed and masturbate without delay.

Believing at last that his soul was lost, he left off praying; and believing that his manhood was lost, he refused to think of marriage. One night, being partly intoxicated, he stayed till morning with an amorous widow, and surprised both himself and the widow with his copulative powers, which had been tried but once before, and that time without success. Perceiving that his poor opinion of himself was without foundation, he went into the society of refined women, and many years ago he married a charming woman, with whom he has lived happily ever since, and by whom he has had two healthy children. D. E. is one of the most brilliant writers connected with journalism."

That there is a certain percentage of people in whom masturbation, always provided it is not indulged in too excessively, will produce no evil effects, or hardly appreciable evil effects, I do not deny; but such people are decidedly in the minority; and in the majority the effects of masturbation are as I described them.

In this connection the reader is also referred to the chapter "Is Masturbation a Vice?" in Part VIII of this book.

CHAPTER ELEVEN

AN OLD TIME WRITER ON MASTURBATION

I cannot refrain before concluding this part of the book from reproducing the description of a case as given by one of the old time doctors. The naiveté of the description, the acceptance by the good old doctor of the young girl patient's diagnosis, his non-analytical post hoc propter hoc reasoning, are all charming. It must be remembered that Homer Bostwick, from whose "Treatise on the Nature and Treatment of Seminal Diseases, Impotency and other kindred Affections" this case is reproduced, was not a quack, but a regular ethical physician. How the doctor knew that the girl got her consumption because of her masturbation, and that she would not have had it otherwise, is a question which will have to remain unanswered. But seventy years ago the members of our profession were not very critical:

A CASE OF DEATH FROM MASTURBATION

Miss R., aged seventeen, the daughter of a highly respectable merchant of this city, was the subject of this case. The unfortunate victim of her own passions was so interesting, and the circumstances of the case were so affecting, that I can hardly bring myself to look upon it from a merely medical point of view.

I was sent for by the father to visit his daughter on the morning of the 10th of May, 1846. When I arrived at

his residence I was struck by the air of comfort, wealth, and quiet good taste which manifested itself throughout the premises. On entering the house, I was immediately invited into the chamber of the invalid, who lay propped up in bed, with a calm smile of resignation upon her countenance, though she knew that death, who had been stealthily but surely approaching her for years, was soon about to claim her as his own. For nearly twenty minutes after I had entered the room, all was as silent as the grave itself; at length the family gradually left the apartment, and I remained alone with my patient.

She was not so much exhausted as to prevent her conversing though her voice was so feeble as scarcely to be heard. I of course asked her many questions concerning her symptoms, the progress of her complaint, etc., etc. She said that, from the questions I asked her, she thought I must know what had brought her into so deplorable a condition; and that this relieved her mind of half its burden, for she felt that she could not bear to die without imparting to someone the dreadful secret which destroyed her, mind and body, and which would doubtless soon carry her to her grave. She had kept all knowledge of the cause of her disease from her family, for shame, more dreadful even than death, had forbade her to tell what she knew was the real truth of the matter. She hurriedly said, "I am evidently in a rapid consumption, which was brought on by the habit of onanism, that I contracted when very young. Though in after years I became aware of the nature of the crime I was committing, and of its fatal consequences, I had not strength of mind to refrain from it, and so continued the practice until it has reduced me to

my present condition. And now, having told you all, I feel so relieved that I am willing to die praying to God for his forgiveness. When I am gone it is my wish that you should communicate this horrid secret to my mother, from whom I have concealed it so long. Tell her to watch over my sisters with unceasing care, so that she may discover and correct in them, ere it is too late, what she never seemed to observe in me; and thus save her children from so untimely and fearful an end as mine. This, doctor, is my last request."

This interview, and the confidence reposed in me, seemed to relieve her mind to such a degree as not only to palliate the symptoms of her disease, but even to restore for a short time her natural vivacity of spirits; and the little powder which I administered to her before I left, received all the credit of this unexpected change — too flattering, for her case was hopeless.

On my next visit I felt it my duty to make known to the father my opinion of his daughter's case, which was, that so far as it was possible to judge, she could live but a few days. I was not deceived, for she died on the 16th of May, 1846, of a wasting consumption. Here we have a striking instance of the fearful consequences of onanism. But it is but one out of thousands of deaths caused by this vile habit — deaths occurring among the female sex as well as the male. Does it need more than the sight of this young, beautiful, and accomplished girl, born to all the blessings of wealth and high position in society, cut down on the verge of womanhood, just as she was about entering on that life for which her fond parents had so carefully trained her, and from which they had hoped so

much happiness both for her and themselves,— destroyed, too, by her own hand, by a sort of protracted suicide,— does it need more than the sight of one such case to sufficiently and solemnly warn all parents against the consequences of this insidious habit? It is not to be dreaded and guarded against only when the child approaches puberty; the practice is often commenced long before. How frequently do we see little girls two or three years of age, who have already contracted the habit of irritating the parts with their fingers; and unless it is stopped, by the severest punishment if necessary, it will grow with their growth and strengthen with their strength, until both growth and strength are destroyed by it. Fathers and mothers, as you value the health, life, and peace of mind of your offspring, watch over, guard, and restrain those natural passions implanted in us for good and noble ends, but which are so often and so wickedly, and, as this touching case has shown us, so fearfully perverted."

I wonder what that good doctor would say if he read, say, Dr. Stekel's opinion on masturbation?

CHAPTER TWELVE

COITUS INTERRUPTUS

Coitus interruptus, vel reservatus, incomplete or interrupted coitus, or withdrawal (or defrauding), is one of the most widespread causes of sexual disorders. As masturbation is prevalent among the young and unmarried, so coitus interruptus is common among married people. It is a serious physical evil with which we must deal frankly and boldly. While its consequences are less injurious than those following masturbation, it has many features in common with it, and its logical place is therefore right after masturbation. It would be quite easy to write a book devoted exclusively to the subject of coitus interruptus. So widespread is the evil becoming and so multitudinous are its results.

That some physicians have denied the tremendously evil effects of this most unnatural form of sexual intercourse is surprising. It can only be explained by their ignorance, by their lack of experience. To me no fact in medicine is more firmly established than the evil influence of coitus interruptus, physically and psychically, on both the man and the woman. That there are some men who may go on practicing coitus interruptus for years without material or ascertainable injury to their health is admitted. Exceptions are to be found everywhere.

I have known men who masturbated most excessively for years and then indulged in regular sexual orgies for

years, who had several attacks of gonorrhea, who became infected with syphilis, and in spite of all this their sexual power remained unimpaired and they did not show a single neurasthenic symptom. But these are exceptions. When we discuss the effects of any mode of life, of any indulgence, of any habit, we have in view the generality of mankind. And on the generality of mankind, I repeat, coitus interruptus has a most pernicious, most blighting influence. If we examined into the history of the thousands and thousands of weak, anemic, irritable, languid, don't-care-if-I-live-or-not men or women, we would find in a vast majority of cases coitus interruptus to be the underlying cause. It is no use arguing abstractly and sophistically, as to what difference it makes whether the semen is deposited in the vagina or outside of it, the fact is that withdrawal at the moment of highest excitation causes a terrible nervous shock to both the man and the woman and the results are as a rule not long in making themselves felt. It could perhaps be objected that I myself am falling into the *post hoc propter hoc* fallacy, that because thousands of people who practice coitus interruptus become impotent and neurasthenic is no proof that it is the coitus interruptus that *causes* it. There might perhaps be other causes at work. But this objection falls to the ground when we state that these cases begin to improve and become well as soon as they abandon the practice of interrupted intercourse.

Several years ago I was struck by the fact that many people at the age of forty, forty-five or forty-eight were in better health and in every respect better than when they were ten years younger. On investigation it very fre-

quently proved that the improvement in their health was due to the fact that, on account of the advance in age or menopause of their wives the danger of impregnation having become very slight or nil, they were enabled to give up coitus interruptus and perform sexual intercourse in the normal, natural manner. I could give numerous cases demonstrating the positive injurious effect of coitus interruptus, but as they would be practically repetitions of each other the following brief reports will suffice:

Case 1. Married 12 years. Has four children. Practicing coitus interruptus for the last five years. Does hard intellectual work. Has himself felt that this method of intercourse was injuring him, but could not help himself as he knew no other method of avoiding more children. Has become very nervous, urinates frequently, erections weak, ejaculations *retarded,* but his worst trouble are frequent night pollutions, and spermatorrhea defecationis. Has lost about twenty-five pounds from his normal weight. Lately has had attacks of vertigo, muscae volitantes, feels a heavy band around the forehead, is afraid to go alone in a crowded street or theater. Severe pains in back of neck, legs feel like lead, feet very cold, so that he must sleep with woolen stockings on. The urine is full of phosphates and oxalates; also contains some shreds, which look like masturbation shreds. He had been treated by a nervous specialist, but without any avail. Prescribed minute doses of cantharidin for the frequent urinating, but told him that he need expect no relief until he gave up coitus interruptus absolutely. He did, and the improvement was immediate. In three months there was practically not a symptom left. The shreds in the urine as

well as the phosphates or urates disappeared without any local treatment.

Case 2. Masturbated as a boy, between 15 and 17. Gave up the habit. Normal sexual relations from twenty-one to twenty-four. Became engaged at that age, married at 25. Never had any venereal disease. Led a normal sexual life for the first three years, during which time his wife gave birth to two children. After the second child began to practice coitus interruptus. A year or a year and a half later began to notice weakened erections and premature ejaculations. At the same time began to suffer with "dyspepsia." Had severe heartburn, annoying abdominal distention after each meal, constipation. Legs felt hot and heavy, was unable to walk three blocks without getting tired and out of breath. Frequent attacks of cardiac palpitation. But the most annoying and distressing symptoms were the change in his character, according to his wife's statement. From cheerful he became gloomy, timid and full of various anxieties. The change in his mood and character was ascribed to his stomach trouble, for which he went from one doctor to another for treatment. When he came to consult me, he had been suffering for five years. He came for treatment for his impotence, but had no idea that his gastro-intestinal trouble had any relation to it. To me the history pointed unmistakably to coitus interruptus as the sole causa peccans. I gave him a placebo, and told him that no treatment would be of any avail unless he began to lead a normal *vita sexualis*. Otherwise his condition would be going from bad to worse.

My advice was followed, and in six months, without any

other treatment, he was a well man. In six months more he was unrecognizable. He was as well as he ever was. His wife's health, which had also been somewhat impaired, became normal too.

A case like this is of more value than all kinds of abstract argumentation.

Case 3. Mrs. X., 32 years old, married eight years. Superb health before marriage. Coitus interruptus since the bridal night, as they didn't think they could "afford" to have children. The first two or three years she did not seem to experience any ill effects. Gradually she began to lose desire for conjugal relations, and the lack of desire subsequently became a loathing. She would have severe pains in the ovarian region, pain in the neck, headaches, would be depressed and irritated in the morning, with throat and mouth dry, and severe palpitation. She gradually developed insomnia, began to lose flesh, became quarrelsome, and cried hysterically at the slightest provocation. Lately she developed severe gastric symptoms — burning in the stomach before and after eating — and a permanent tachycardia. Pulse always over 100. Legs tremble at slightest exertion or excitement. Well-defined anxiety neurosis, and talks of death and suicide. Objectively nothing could be found, except the rapid pulse. Coitus at the present time only about once in two weeks, and always feels worse after. A talk with the husband elicits the information that he practiced coitus interruptus only with his wife as he did not wish to have any children, but that during all these years he also had relations with other women in a perfectly natural way. His potency and general health are unimpaired, and it did not

come to his mind that the coitus interruptus had anything to do with his wife's having become a wreck.

Coitus interruptus forbidden absolutely, and a complete sexual rest for two months ordered for the wife. After that resumption of normal intercourse. Also general tonic treatment, massage and hydrotherapy. Improvement immediate, but it was ten months before the last symptom, trembling of the legs, disappeared.

Case 4. Miss A., a school teacher. Coitus interruptus for the last three years. Presents sexual neurasthenic and hysterical symptoms. Anxiety neurosis pronounced. Is always afraid something is going to happen, though she can not give any account of what that something is or can be. This, however, I admit is not a proper case to draw any conclusions from, because here the fear of impregnation, on account of her unmarried condition, is so great that in itself it is capable of causing all those symptoms.

She was advised to give up all sexual relations, for a time at least, which advice was followed with decided improvement in all symptoms, both somatic and psychic. She soon married, her sexual life was normal and her health remained good.

Case 5. Miss B. This case is similar to the previous one, but is more conclusive. She is also a school teacher, and the indulgence in coitus interruptus produced such severe disturbances, that she thought she would be obliged to give up school. She learned of a different method of prevention, and since she gave up coitus interruptus, her health has improved in every respect; in fact she states it is better than it ever was.

Case 6. A very remarkable case. Patient came into

my hands only two months ago. Family history excellent, himself always full of the "joy of life," though somewhat high strung and "nervous." Married nine years. Has two children. The second labor was so difficult that it nearly cost his wife her life; she had some sepsis after the second child, and has never been perfectly well since. For the last five years coitus interruptus. For the last two years complete lack of libido, as if "he was not a man at all." Practices intercourse only once in five or six weeks, *but the intercourse is not followed by any ejaculation;* only later in the night when he falls asleep there is an abundant pollution. In the morning he feels extremely exhausted and depressed. He feels so "unhappy," that he would like to cry, go away and see nobody. To see or talk to people is a torture to him. The last year has been suffering off and on with obstinate insomnia; for a month or two he will sleep well, then for a month or more he will suffer with the most obstinate insomnia, for which he has been taking doses of veronal; following the veronal, he will feel more depressed than ever. The anxiety neurosis is very pronounced. Wants to die and is very much afraid to die. Imagines everybody knows what is the matter with him. Pulse generally about 80, but under the least excitement runs up to 100-108. Distention of the stomach after eating. Constipated. Had never consulted a physician for his condition, as he felt ashamed. Investigation revealed the fact, ascertainable in so many of these patients, that at first the attempt at withdrawal cost him a "superhuman" effort. He would have to gnash his teeth, and strain every muscle in his body, while doing it. Gradually it cost him less and less effort, but the ejacula-

tions became also gradually retarded, until as stated above they ceased altogether. All this pointed unmistakably to coitus interruptus being the direct cause of his condition.

I laid out a course of hydrotherapeutic and general tonic treatment, forbade intercourse absolutely for six months. I saw the patient yesterday. The improvement in his psychic condition is remarkable. He feels a new man. For the first time in months he felt a stirring within him of his old libido, and he feels confident that he will get well. And so do I. Though the patient is not well yet, sufficient time has not yet elapsed for a final result, still I consider it worth while reporting, as showing what coitus interruptus may do even with an apparently perfectly normal and healthy man.

Those who have not seen and are therefore skeptical about the very injurious effects of coitus interruptus are apt to raise an objection to the effect that the cases I have given were probably not perfectly normal to begin with, that they were probably of a nervous temperament, that their parents were neurotic, that they had a hereditary taint, etc. I am not going to discuss this point very heatedly, because, as I said elsewhere, I do not believe in a perfectly normal human being. Where is that mythical thing a perfectly normal, a perfectly healthy man or woman? The apparently perfect specimen sometimes contains deeply hidden a very dangerous mouldy spot. And who can tell that some of our ancestors did not possess some physical or mental defect, which he transmitted to his grand-grandchildren? This is all childish talk. We have to take humanity as it is. In discussing human nosology and pathology we do not deal with the exceptions

at either end of the scale; we leave out the five percent at either end and take the middle ninety. Or say ten percent at either end and take the middle eighty. And on the middle ninety or eighty percent coitus interruptus produces an effect as described.

Coitus Protractus (and Interruptus Protractus). Some men in a desire to prolong the pleasurable sensation of the sexual act, or out of chivalry for their partner who may be very slow in reaching the orgasm, intentionally prolong the act as long as possible, using their utmost will-power to delay the ejaculation. They may thus become practiced in making the act last five or ten minutes (all the stories of *uninterrupted* coitus lasting half an hour or an hour are silly fables of brainless braggarts). Or they may repeatedly withdraw the organ (when near the point of culmination) and thus prolong the act for an hour or more. To this method the term interruptus protractus is applied. Both methods are extremely injurious. And the worst cases of paralytic impotence in my practice were in men who had practiced the above methods. And again, unscientific as it may sound, I believe that prolonged indulgence in such practices may lead eventually to locomotor ataxia. That it would have a tendency to act in this direction in a person who has had syphilis I have no doubt. A syphilitic may have tabes without coitus protractus, but he is twice as likely to have it with it. The same is true of *coitus ab ore.*

The woman who insists upon such methods of gratification should be gently but firmly repressed. If she persists, she should be gotten rid of as soon as possible — whether wife or mistress.

Coitus Incompletus. Incomplete or rather non-completed coitus. Some men have a curious notion that any loss of semen is injurious and weakening to the system. They believe that by retaining the semen it is reabsorbed by the organism, and revitalizes it, energizes it, and what not. Under this mistaken and pernicious impression these people learn to perform intercourse without any ejaculation. As soon as they feel there is danger of a seminal emission, they withdraw. By the exercise of will-power they gradually learn to prolong the act considerably, but without bringing it to a climax. It is well known that for years this method of sexual relations has been practiced by the members of the Oneida community, and we find it in use sporadically here and there. I cannot find words strong enough to condemn this practice. While there are isolated individuals who are apparently not hurt by this unnatural method — you can always find isolated instances of people who are apparently not injured by the most unhygienic and ordinarily most injurious practices — still, as a general thing, it is about the most damnable practice imaginable. I have had two patients who had attempted this method for one and three years respectively. They were both extremely neurasthenic, their prostates were enlarged and atonic and the posterior urethra was intensely congested in both cases.

The effect on the woman of this method of coitus varies. Some do not seem to mind it, in fact even appreciate it highly, but sooner or later neurasthenic symptoms do not fail to make their appearance. Some women feel irritated and unsatisfied by any mode of coitus which does not cul-

minate in the unhindered and unobstructed discharge of spermatic fluid.

The Treatment of Coitus Interruptus. The only treatment of the various abnormal methods of coitus is their immediate discontinuance. As to the results of coitus interruptus, protractus, etc., they express themselves in varying degrees of impotence and neurasthenia, and the reader is referred to the chapter on The Treatment of Pollutions and Spermatorrhea, The Treatment of Sexual Impotence and The Treatment of Sexual Neurasthenia. It is well to emphasize, however, that where the symptoms are not very severe they often disappear without any treatment on the mere discontinuance of the abnormal method.

COITUS CONDOMATUS

We are frequently asked as to the injuriousness or non-injuriousness of the use of condoms. While much less harmful than withdrawal, it is not by any means entirely free from evil effects. The percentage of people, however, in whom coitus condomatus proves unmistakably injurious is rather small. But small as it is, it must be counted with. The principal bad effect is a feeling of irritation and unsatisfaction. I mean a general nervous irritation. In some cases there is also a slight local urethral irritation. On prolonged use the ejaculation sometimes becomes considerably retarded. This is in itself a phenomenon which is rather welcomed by both the man and the woman. But in a few cases, the ejaculation finally ceases to take place altogether, and this leaves the man in a very unsatisfied, exhausted condition.

On the woman coitus condomatus has, *as a rule,* no evil effect. Some women, however, are left by it in a very irritable, unsatisfied condition, a condition of disgust. Some begin to loathe it so, that they prefer not to have any coitus at all than to indulge in coitus condomatus.

Some get into a sort of frenzy during the act so that they pull off the condom, and this regardless of consequences; *i. e.,* the spectre of pregnancy.

PART II

POLLUTIONS AND SPERMATORRHEA

CHAPTER THIRTEEN

POLLUTIONS: DEFINITION AND CLASSIFICATION

The etymological meaning of pollutions is defilement, uncleanness (from Latin, polluo — defile), but the briefest and I believe the best definition of pollutions in the medical sense is: Involuntary seminal emissions. Whether they occur in the night or in the daytime, or rather in sleep or during waking hours, the element of involuntariness must be present. Pollutions may occur at any time, from the beginning to the end of man's sexual activity, that is between the ages of ten and eighty. I know of cases in which pollutions occurred even at an earlier age, in sexually precocious boys. But ordinarily they begin to manifest themselves at the age of twelve or thirteen.

Physiologic and Pathologic Pollutions. Pollutions are generally spoken of as physiologic and pathologic. Some sexologists claim that in the strict sense of the term there is no such thing as a physiologic pollution. I will touch, however, on this point later, and will maintain the division of pollutions into physiologic or normal and pathologic or morbid, as a matter of convenience. What are the characteristics of normal pollutions? How and under what circumstances must they occur to be entitled to be classified as physiologic? The conditions of normal pollutions are as follows:

1. They must occur during sleep.

2. They must not occur with undue frequency (this point will be discussed further).

3. They must be accompanied by a strong erection.

4. They must be accompanied by an erotic dream.

5. The ejaculation must be accompanied by a voluptuous sensation.

6. And last, but not least, the pollutions must not have any debilitating or depressing effect on the patient. He must feel in the morning refreshed and buoyant as after a normal coitus.

In other words, pollutions to be designated as physiologic must have practically the characteristics of normal intercourse. As soon as they begin to deviate from the conditions which we have outlined, they begin to be pathologic, and the greater their deviation the greater their pathologic significance.

Pollutions that occur during waking hours or too frequently, or that are not accompanied by erections, erotic dreams or voluptuous sensations, or that leave the patient on the following day depressed, languid, unable to work or concentrate, with a dull feeling in the head or pain in the neck and spine, etc., are distinctly pathologic and must be treated energetically and without delay.

I used the term "undue frequency"; I know it is an unsatisfactory expression, one of the expressions employed when we wish to avoid specific statements. What is the proper frequency and what is undue frequency? Are we justified in establishing a normal interval, and say that any smaller interval is abnormal? We are. I am as well aware as one can be of the vast differences existing in the

sexual spheres of different men, and nevertheless we are justified in accepting a certain criterion, a certain average. If pollutions occur not oftener than about once in two weeks, or at the very most once a week, and if they do not cause symptoms of weakness and depression they are within the limits of the normal. If they occur twice a week or oftener they *are pathologic, even if they leave the person in a buoyant, refreshed condition.* For we have here a great danger, the danger of the *pollution-habit.* While there are people who can and do live for years in good health with the pollutions occurring with about the same frequency, the general tendency of pollutions, if left untreated, is to increase in frequency and to lose in intensity, and in the erotic elements, i.e., their tendency is to pass from physiologic into pathologic. And it is the part of wisdom to treat them while they are still in the former stage.

We stated that the pollutions are apt to pass, sometimes imperceptibly, from the physiologic into pathologic. First, they increase in frequency. They may become as frequent as once every night, or even oftener. They may occur three or four times a night. (I have now a patient under treatment who had had ten to fifteen pollutions a week for several months.) Then with the increase in frequency, the erection and the voluptuous sensation become less and less, until they disappear altogether. While in the beginning the patient would wake immediately before or during the ejaculation, he has now the pollutions without any sensation; he now awakes only when the pollution is all over, or only in the morning from the stains on his underwear and bed linen does he

become aware that he has had a pollution. The dreams which were strongly erotic and pleasurable gradually lose this quality and may assume an entirely non-sexual character.

In one of my patients the frequently occurring pollutions were always preceded by a dream of a mathematical nature. He would dream that he had to multiply two large numbers, and the painful and unsuccessful efforts to complete the problem would result in a pollution. Another patient would try to repeat a certain poem by heart, and the pollution would follow the failure to remember the lines. Another patient would dream that he had to catch a train or a steamer; the slow movement of the trolley-car which was to bring him to the train or steamer would exasperate him and result in a pollution. These pollutions kept up for over a year, repeated every two or three nights, and had brought him to the state of a "nervous wreck" when he came for treatment. It will be observed that the non-sexual dreams resulting in a pollution generally represent some unsuccessful, some unpleasant effort. It is never a successful, pleasant experience (i.e., of a non-sexual character) that results in a pollution.

The dreams may assume the character of some sexual perversion, and then the pollutions may occur without any dream whatever.

The ejaculation which at first caused an intensely pleasurable, voluptuous sensation, also gradually loses this quality, to be eventually followed by no sensation at all, and this is finally succeeded by an unpleasant feeling of *burning* and *scalding* in the urethral canal.

The most important point, however, is the effect of the pollutions on the physical and mental condition of the patient. These will be considered after we have considered diurnal pollutions and spermatorrhea.

Diurnal Pollutions. Diurnal pollutions are seminal emissions occurring during the day. But a better term would be "waking pollutions," because it is not the time of the day that is important, it is the sleeping or waking condition of the patient. While sleep pollutions may under the conditions we have enumerated be "physiologic," waking pollutions never are. Every diurnal or waking pollution is unquestionably abnormal, and at the appearance of the first one, energetic measures must be taken to avoid a second one. Diurnal pollutions signify a neurasthenic condition, an irritable condition of the nervous centers, a weakness or hyperesthetic condition of the genital organs. Long continued and frequently repeated sleep pollutions are often, though not necessarily, followed or accompanied by waking pollutions. The latter may, however, arise in people who suffer but moderately with the former. Whether diurnal pollutions can occur in people whose sexual organs and centers have not been weakened by nocturnal pollutions or masturbation is an open question. I have had a young patient who assured me that his very first pollution was a day pollution, which took place while he was witnessing a certain musical comedy show, and that only after that pollution he began to suffer with night emissions, but I am not so sure that the masturbatory element could be entirely excluded in this case. While I believe the patient that he never had night emissions or masturbated before that time, I believe that there

was some perhaps unconscious friction which helped to bring on the emission.

If diurnal pollutions continue for any length of time, a lesser and lesser stimulus is required to bring them about. Mere proximity to a woman, the touching of woman's clothes, examination of female attire, underwear or corsets in show windows or in the advertising pages of magazines, the sight of nude pictures or statues in the museums, of questionable theatrical posters on the billboards, the witnessing of any musical comedy or even drama or opera dealing with sex (like " The Easiest Way " or " Salome "), the reading of any pornographic trash, or even high class literature of a realistic character, such as that of Zola or Maupassant, bicycle riding, dancing, or horseback riding is apt to bring on a pollution. *Being manicured or getting a shave or shampoo is sufficient to do it.*

And it is a curious, though well established fact that the stimulus or irritation bringing about the diurnal pollution need have no reference whatever to anything sexual. Anything causing mental strain, or effort, or anxiety is apt to bring one on. For instance, I have known young men attending college who would have emissions during examinations, when they would try to recollect something, or when they would try to solve a difficult mathematical problem. I have now a bookkeeper under treatment, who would occasionally suffer with emissions whenever a mistake would occur and the figures would not tally after several attempts at correction. One patient, who used to suffer with frequent night emissions, got his first day emission while being cross-examined on the witness stand, and since then almost every kind of excitement would be sure

to bring one on. Another one got his first diurnal pollution while waiting for the verdict of the jury in a case in which practically his entire fortune was at stake.

Retro-Pollutions or Pollutions into the Bladder. A form of pollution that is not well-known and that is considerably more frequent than one would think is retro-pollution, or pollution into the bladder. A patient will tell you that he had lascivious dreams, that he even thought he had an emission and still he found no sign of it when he woke up. When you examine the first morning urine of such a patient, you may find it full of semen. It settles down quickly from the turbid urine in the form of a cloud or a gelatinous mass, but one experienced can at once detect it, even without any close macroscopic or microscopic examination. Merely glancing at the urine is sufficient. People who suffer with atonic pollutions, unaccompanied by any dreams also have the semen not infrequently regurgitated into the bladder. They may thus have pollutions for a long time and not be aware of them. In fact they will tell you that they used to suffer with pollutions, but now they have stopped, and nevertheless they wake up in the morning terribly exhausted and depressed. Only an examination of the morning urine reveals to the physician the existence of this most dangerous form of pollution.

This form of pollution may occur under two conditions. It may be due to a tight or spasmodic stricture. The semen may be sent out with force but meeting an obstruction, it goes into the path of the least resistance.* Or it

* We meet with a similar condition in sexual intercourse. There are cases in which no amount of friction will bring about an external ejaculation. The semen runs into the bladder.

may occur in atonic pollutions, when there is practically no erection, and the semen being emitted without any force, runs back into the bladder. And when a patient complains of waking in the morning tired and exhausted and of other symptoms suggesting pollutions, but affirms that he has no pollutions, his morning urine should be examined for semen. Some emissions take place partly externally and partly into the bladder. I generally order my gonorrheal patients to come in the morning with a full bladder. On examining the urine for shreds, we often find some semen too, and to the question: Have you had a pollution last night? the answer is generally in the affirmative.

Another form of pollution is to be mentioned: masturbating pollution. Confirmed masturbators from the habit of handling their genitals often do the same thing unconsciously in their sleep. They either wake when it is all over, and then they think that they are the victims of pollutions or they wake with their hands still manipulating the organ. Of course, here we really are not dealing with pollutions, but with unconscious or involuntary masturbation.

Is There Such a Thing as a Physiologic Pollution? As mentioned before, some sexologists consider the term physiologic or normal pollution as a misnomer. They claim that every pollution is abnormal. For, people living a normal sexual life, that is, people having regular sexual intercourse, have no pollutions. A pollution always signifies an overfilling of the seminal vesicles, a local or general irritation, atony of the ejaculatory ducts, or erotic dreams,— all results of unnatural continence. Some even

go to the point of saying that pollutions are no more physiologic or normal than nocturnal enuresis is. And strictly speaking they are right. Nevertheless, we have a right to speak of normal pollutions if by that term we simply mean pollutions occurring occasionally in healthy men as a result of continence and producing no depressing effect. And it is in that sense that I wish it understood the expression is employed by me. Under a *natural* system of society, pollutions would be a rare phenomenon and would always be considered abnormal.

CHAPTER FOURTEEN

CAUSES OF POLLUTIONS

The great basic cause of pollutions is continence. As just stated, if all men lived a normal sexual life from maturity to the extinction of the sexual faculties, pollutions would be only a rare and exceptional phenomenon. We are told that pollutions are unknown among primitive tribes or among animals. But civilization, by which we mean our social-economic conditions and our moral and theologic codes, imposes very decided restrictions upon the satisfaction of the sexual impulse. A large percentage of men get married many years after attaining maturity, and many remain unmarried through life. And as the opportunities for illicit intercourse are limited and at best unsatisfactory, many men have abstinence imposed on them, voluntary or involuntary, which is often irksome, often extremely annoying and unhealthy. And as nature must find a safety valve, an outlet for the accumulated seminal secretion, as the seminal vesicles can only stand a certain amount of distention, pollution is the result. And so the broad normal cause of pollutions is continence.

But there are many factors which aggravate pollutions, increasing their frequency and persistence. First, among these causes is masturbation. Masturbation puts the genital organs into an atonic condition, so that emission takes place at the slightest stimulation. Both susceptibility and irritability is increased and the resistance is lessened.

Other causes are: an uncured posterior urethritis, chronic inflammation of the colliculus seminalis, patulousness of the ejaculatory ducts, and prostatitis. Rarer and incidental causes are eczema and pruritus of the anus and scrotum, fissure of the anus, alcohol, particularly beer and ale, cantharides taken for their reputed aphrodisiac effects, an overfilled stomach, a full rectum, a full bladder, an overheated room, too warm covering, *cold feet* from insufficient covering; dallying with women, reading salacious literature or witnessing obscene shows, in short keeping the mind centered on sexual subjects, is an undoubted cause.

Another important point: medical treatment will sometimes aggravate pollutions. This is particularly true of metal sounds and of silver nitrate instillations; any irritating injection, particularly if administered at night, is apt to bring on a pollution in those predisposed to it. Physicians must therefore use a good deal of judgment in treating patients, predisposed to or suffering with pollutions, in whom urethral instrumentation or strong posterior instillations are necessary. The treatment must be very mild in the beginning. Prostatic massage seems sometimes to be a cause of pollutions, but not frequently.

CHAPTER FIFTEEN

POLLUTIONS AND NOCTURNAL INCONTINENCE OF URINE

The connection between noctural incontinence of urine or bed wetting and pollutions, spermatorrhea and sexual impotence is an interesting and important one. The urinary incontinence and the sexual weakness are often expressions of the same primary condition: a motor neurosis, an atony of the genito-urinary tract. For years I have made it a point to ask every patient suffering with any form of sexual weakness as to his bed wetting in childhood. And I was surprised at the frequency with which the patients answered the question: — sometimes after a little hesitation — in the affirmative. Some suffered with that infirmity to quite an advanced age, 12, 13 and 15; and some were unable to get rid entirely of that annoying and humiliating habit even in adult life. As I wrote in a former article of mine, I was so struck by the relationship between bed wetting and sexual weakness, that I thought I had made quite a discovery and was about to announce it as such in our medical journals. But on searching through the literature on the subject, I found that the great clinical observer Trousseau had noticed the connection many, many years ago, and others even before him. So I failed to become a discoverer. As I remarked in the above referred to article many so-called recent discoveries were discovered long ago, only the discoverers don't know

it, because they don't take the trouble to search through the old literature.

The relationship between incontinence of urine in childhood and sexual weakness in later life is not merely of academic interest; it has a deep practical significance, and its lesson is that every case of incontinence in a boy should be treated persistently until the boy is cured. By neglecting incontinence you may be marring the whole future life of your child. Urinary incontinence is a signal that the boy's genito-urinary apparatus is not in perfect order, and it is a sin not to heed the signal.

Of course nocturnal enuresis in girls must also be treated energetically, as it is here also an expression of a neurosis. While it may not spell impotence, it often portends masturbation and sexual neuroses.

CHAPTER SIXTEEN

SPERMATORRHEA

Spermatorrhea means literally a running of semen. While we do but rarely meet with those terrible cases described by Lallemand and Tissot, in which the semen was oozing from the patient continuously, still the cases of true spermatorrhea which we encounter occasionally are very sad indeed. At the least provocation, whether it be mechanical friction, tight trousers, some discomfort, a full rectum or bladder, some picture or mental image, the act of micturition or defecation, or even without any ascertainable provocation, there is a discharge of semen, real spermatozoa-containing semen. And all this without any libidinous thought or voluptuous sensation, without even the patient's consciousness. He will feel the meatus wet or sticky, and on examination this fluid will be found to contain spermatozoa, though they may be few in number, somewhat deformed and but slightly motile.

Spermatorrhea is the last link in the chain of abnormal seminal losses. First, we have "physiologic" sleep pollutions, then pathologic sleep pollutions, then diurnal or waking pollutions and finally spermatorrhea. Spermatorrhea may also supervene without antecedent pollutions, namely in excessive, "furious" masturbators, especially when they attempt to break the habit. But even while the habit is still being kept up, spermatorrhea may make its appearance.

The masturbator irritates and weakens the erectile and ejaculatory centers; at the same time he induces such a congestion of the posterior urethra and atony of the seminal vesicles and ejaculatory ducts, that the condition of spermatorrhea is established. Whether spermatorrhea may supervene upon sexual excesses, i.e., excessive normal intercourse, is very doubtful. I have seen some cases of alleged spermatorrhea following sexual excesses, but on examination the "spermatorrhea" proved to be prostatorrhea. True spermatorrhea may also occur in the course of severe spinal disease. Thus Fürbringer saw a case of spermatorrhea in the course of a severe myelitis.

CHAPTER SEVENTEEN

SYMPTOMS OF POLLUTIONS AND SPERMATORRHEA

The range between pollutions, which occur occasionally as a relief to an overfilled sexual system, and the spermatorrhea of the extreme degree, which threatens the patient's mental and physical integrity, is so great, that the symptomatology is necessarily extremely varied, ranging from mild, hardly noticeable, phenomena to symptoms which make life a burden to the patient and to those around him. As a matter of fact, the symptoms in so-called physiologic pollutions often are those of euphoria, that is, the patient's well being is increased, he feels refreshed, his head is clearer, there is a better spring to his walk and he is more keen for work. But as the pollutions increase in frequency, or become aggravated by diurnal pollutions and spermatorrhea, the picture changes entirely. Here is the composite symptomatology of a patient suffering with severe night emissions, diurnal emissions and spermatorrhea.

Symptoms. Objectively the penis is found cold and shriveled and less sensitive to the electric current; the testicles are small and tender to the touch. The prostatic portion of the urethra is as a rule excruciatingly, exquisitely sensitive. The patient complains of headaches, of pains in the back of the head, of weakness in the muscles of the neck and of the spine, of a general uncomfortable

sensation in the perineal region. He may also complain of migraine, of *muscae volitantes,* and in some cases the black rings around the eyes are very characteristic. His tongue is generally coated, he either has no appetite, or he eats voraciously, he is constipated, though occasionally the constipation alternates with diarrhea; he may have attacks of nausea, vomiting, severe heart-burn, and he often suffers from hyperacidity which is later followed by hypoacidity. The digestive disorders may bring about severe emaciation. The patient's circulatory system is decidedly affected; he is unable to walk upstairs or run after a car without getting out of breath, and palpitation of the heart is very common; this palpitation may occur after the slightest physical effort, after stooping, after eating, or after the slightest mental excitement, or after each seminal loss. There is a general feeling of languidness and lassitude; his legs feel hot and heavy in the afternoon, and as he passes the last drops of urine, there runs a quiver through his spine and body (a symptom, by the way, which I do not remember having seen mentioned by any other author), and he may also experience neuralgic pains in the testicles.

But serious as the physical symptoms may be, the mental symptoms are more so. I am not referring to the hypochondriac notions induced in young innocents by the reading of quack literature. I refer to real symptoms, which we may notice in the most level-headed persons, who are doing their utmost to fight and overcome them. The most prominent of those symptoms is a LACK OF CONCENTRATION, inability to work steadily and continuously. A person suffering with frequent nocturnal or diurnal pol-

lutions and spermatorrhea can seldom hold a good position requiring steady mental concentration or initiative. He may work in spurts and turn out good work, but he cannot do it steadily. Every once in a while his mind becomes a blank and he is then, as he expresses it, "good for nothing."

Another striking symptom is "LACK OF AMBITION." This is not a fanciful term, but expresses a true state of affairs. The patient does not care what happens; he does not care whether he is successful or not; he is "oversatiated" with life. These are disagreeable patients to treat, but if you handle them gently, inspire them with confidence and really improve their condition, they gradually regain the *joie de vivre* and become exceedingly grateful and obedient. Another distressing symptom is LOSS OF MEMORY. This loss of memory in subjects suffering with excessive seminal losses, from whatever cause, has always been an extremely interesting subject to me. It shows, as nothing else can, the intimate relationship between the brain and sexual organs. The excessive drain of a vital fluid of highly phosphorized nucleo-proteids, cannot but eventually affect the brain. And it is remarkable that as soon as you succeed in stopping the pollutions or the spermatorrhea, the memory returns. This is one of the important symptoms to show you and the patient that the treatment is really effective. For, of course, a mere improvement in the general condition, such as increased appetite, greater physical vigor, etc., is not difficult to produce in any patient.

As to the sexual condition of such individuals. The libido sexualis is, as a rule, diminished, though in a cer-

tain percentage of cases it is increased. The power, however, is invariably diminished. The patients are at least partially impotent, and there is, and this almost without exception, ejaculatio praecox.

As to the relationship between severe pollutions or spermatorrhea and tabes dorsalis, various psychoses, paralytic dementia, etc.: what I said about the relation of those diseases to masturbation, applies equally to pollutions and spermatorrhea.

Defecation and Micturition Spermatorrhea. From the condition of spermatorrhea just described which is of the gravest import to the patient's physical and mental health, we must separate two milder forms, defecation spermatorrhea and micturition spermatorrhea. During defecation, especially when the feces are hard and the patient has to strain, a few drops of seminal fluid appear at the meatus. This is due to the contraction of the perineal muscles and the seminal vesicles, and may appear occasionally even in perfectly healthy men. Defecation spermatorrhea is therefore the mildest form of the disorder, and, if it occurs only with defecation, is not of much pathologic import, though the patients are badly scared. Micturition spermatorrhea, when the semen is lost at the end of micturition, when the patient contracts his perineal and abdominal muscles in an attempt to void the last drops of urine is more serious, and should always be treated, because this form is already indicative of considerable atony of the seminal vesicles and ejaculatory ducts.

So in the order of their seriousness we have: defecation spermatorrhea, micturition spermatorrhea and general spermatorrhea.

CHAPTER EIGHTEEN

PROSTATORRHEA

Prostatorrhea signifies the running or loss of prostatic fluid. It may occur only during defecation — the most frequent variety,— during micturition, after a brisk walk, or in atony of the prostate practically at any time, and without any cause.

The importance of prostatorrhea arises partly from the fact that it is always taken by the patient (who is, of course, not expected to know the difference), and not infrequently also by the physician, for true spermatorrhea. While prostatorrhea is a much less serious disorder than spermatorrhea, still its significance must not be too much underestimated. Our knowledge of the prostate — one of the most interesting glands in the body — and of its secretion is still very imperfect, but the suspicion is getting stronger and stronger in scientific circles that the latter plays a much more important rôle than has been attributed to it. That the prostatic secretion is important for the vitality, for the very integrity, and fertilizing power of the spermatozoa we know; but the prostate may also be contributing some internal secretion of the highest importance. And the frequent loss of prostatic fluid such as takes place in prostatorrhea cannot be a matter of indifference. The fact remains that many patients who suffer with prostatorrhea, frequently feel as wretched, as depressed and debilitated as do patients suffering with sper-

matorrhea — and this even after they have been assured and have become convinced that their disorder is not of great importance. The positive differentiation between prostatorrhea and true spermatorrhea can be made by the aid of the microscope only. The invariable characteristic of spermatorrhea (except in cases of azoospermia) is the presence of spermatozoa. In prostatorrhea the fluid is thinner, has a weak alkaline reaction, and the microscope shows the presence of lecithin corpuscles or granules and of Böttcher's crystals, and *no* spermatozoa.

Spermaturia means semen in the urine. We find this condition in retro-pollutions, or pollutions into the bladder, which we discussed before, and in true spermatorrhea. In these two conditions the semen is present in every portion of the urine. In the condition known as micturition spermatorrhea, the semen is present in the last portion of the urine only. The first portion may be entirely free from semen.

CHAPTER NINETEEN

URETHRORRHEA

Much less important than either spermatorrhea or prostatorrhea is the condition known as urethrorrhea. While the etymology of the word is a most barbarous one, it has acquired a definite meaning and we may as well retain it instead of trying to introduce a new term. By urethrorrhea we understand a clear, transparent, non-bacterial and non-infectious mucous discharge from the urethra. It is in short simply an increase in the amount of the normal discharge of the normal urethra. It may occur habitually after a perfectly cured gonorrhea of long standing. It is not infrequent in excessive masturbators. The special kind of urethrorrhea which scares and sends to the doctor so many young men is *urethrorrhea ex libidine*. In many men, young and old, any sexual excitement is apt to make a few drops of a clear, glycerin-like, somewhat tenacious fluid appear at the orifice of the urethra. This is the increased secretion of the glands of Littré, Cowper and Morgagni, and if appearing but occasionally is of no significance. But the patients get frightened and are sure that they are losing their semen, and are apt to become very hypochondriacal and even psychically impotent. An examination under the microscope shows the fluid to consist of simple mucus and a few epithelial cells. Neither spermatozoa, nor lecithin granules, nor Böttcher's crystals are present. In normal pa-

tients, a mere explanation of the real condition is sufficient to remove all worry. In sexual neurasthenics the matter, however, is not so simple. You can explain and explain, they still remain convinced that something terrible is the matter with them, that they are losing their "nature" and their manhood.

While, as stated, *urethrorrhea ex libidine,* if occurring occasionally is of no significance, it does not mean that it should not be attended to; for it carries in it the danger of all deviations from the normal: if neglected, if the causes responsible for the urethrorrhea be not removed, the condition may become aggravated, the secretion becomes larger in amount, more watery, turbid, the urethral mucous membrane loses its resistance and a bacterial infection may take place. That the causes responsible for the urethrorrhea, such as long engagements with unsatisfied sexual desire and frustrated excitement, may also bring about a hyperemia of the posterior urethra, with premature ejaculations and relative impotence, goes without saying, but these conditions are concomitant effects of the same cause; they are accompanying phenomena, and not the result of the urethrorrhea.

CHAPTER TWENTY

THE TREATMENT OF POLLUTIONS AND SPERMATORRHEA

The statement that it is the patient and not the name of the disease that is to be treated has become threadbare with use. It is true, however, and of no class of diseases is it more true than of sexual diseases. He who intends to treat sexual diseases by set formulas, by prescriptions copied from old text-books, courts failure from the outset. It is of the utmost importance, it is an absolute *sine qua non* of successful treatment to determine the stage of the disease, for the remedies that will prove of great benefit in the "plethoric," irritable stage, will aggravate the condition, aggravate it very much, if administered in the atonic, "paralytic" stage, and vice versa.

It is so important to impress upon the reader's mind this distinction that I will spend a few moments in illustrating my statement with one or two examples: The average practitioner knows in a general vague way that potassium bromide is useful in pollutions. Yes, it is. But in what stage? It is useful in healthy individuals, leading a more or less continent life and when the pollutions are accompanied by erotic dreams. In this condition the bromides may sometimes prove remarkably beneficial. When the pollutions occur, however, with great frequency, with very weak erections, or even without the person's consciousness, the bromides are positively perni-

cious. They are just as pernicious and injurious in spermatorrhea. And still they are prescribed indiscriminately. Dozens and dozens of times have I seen patients complaining that since taking a certain treatment their condition became worse. On examining their medicine I would invariably find potassium or sodium bromide.

The same is true of strychnine. Strychnine is very useful in the atonic stage, but if administered in the plethoric or irritable stage it will prove injurious. Even cold baths or cold ablutions may prove harmful and may increase instead of diminishing the seminal emissions. In short, it is absolutely necessary to individualize, and individualization of every case should be our watchword. And these remarks will serve to illustrate how much benefit may be expected from the "lost-manhood" treatments advertised by the various charlatans and harpies that prey upon the credulity and weakness of mankind.

Psychic Treatment. The treatment of any case of sexual disorder must be of three kinds: psychic, general and local. By psychic treatment I mean explaining to the patient his exact condition, taking away his exaggerated fears, and making it clear to him that with a little patience and help from his side, he can be cured, completely cured. We all know what exaggerated notions — fostered by quack literature — our lay and even medical patients entertain about seminal losses. A patient who notices a drop or two of semen — which may not be semen at all, but prostatic fluid — exuding from the meatus after defecation, is sure that he is on the straight road to the insane asylum. Of course these depressed thoughts influence his entire system and a vicious circle is soon estab-

lished. When you explain to him, however, that in one normal connection he loses more semen than he can lose in the other way in a week or two, and when you explain to him that the loss of a few drops after defecation is almost entirely a mechanical phenomenon, due to the pressure of hardened feces on the seminal vesicles, to the contraction of the muscles, etc., his fears are allayed and he enters upon the treatment more hopefully. I do not advocate ridiculing the patient's fears or telling him that his condition is "nothing." The latter is absurd, for the condition is not "nothing," but it is necessary to put things in their true perspective. Always explain to the patient his condition honestly, truthfully; this will gain you his willing, intelligent coöperation — and half of the battle is then won.

The General Treatment. In night pollutions, occurring in healthy individuals, accompanied with erections and erotic dreams, the bromides are of unquestionable value. I generally prescribe 10 to 15 grains of strontium bromide or sodium bromide at 4 P. M., the same dose at 8 P. M., and 20 to 30 grains on going to bed. Occasionally, I combine the bromide with lupulin and camphor monobromide, and in still more obstinate instances with hyoscyamine. A favorite combination of mine is the following:

℞ Strontii bromidi............gr. v
Camphorae monobrom......gr. ii.
Lupulini optimi............gr. v
Hyoscyaminae hydrobr.......gr. 1-100

M.f. caps. No. 1. Tales doses xx.

Sig.: One at 8 P. M. and one on going to bed.

Why this combination should be so efficient I do not

know. But that it is efficient, I do know. I know from the results in *hundreds* of cases in my personal practice, and I know it from reports of physicians in various parts of the country. I had printed this formula once in *The Critic and Guide,* and very soon after its appearance, physicians — and laymen too — began to write to me of its marvelous efficiency.

It is here that the physician so often sins in ordering ablutions with cold water. Cold water is followed by a reaction, which as a rule increases the erections and emissions. Ablutions, if ordered at all, should be with lukewarm water, and should not be followed by active rubbing. Dry gently by merely applying the towel or allow to dry spontaneously. Constipation or hardened feces must be guarded against by all possible means. Cascara, saline laxatives (but never aloes!), gluten (but no glycerin) suppositories, enemata — anything to prevent constipation, hardened feces and straining at stool. Beginning at about 4 P. M., the amount of liquids should be reduced considerably, while alcoholic liquids should be prohibited absolutely. Smoking in this stage is rather beneficial. (As will be seen, in the atonic stage an entirely different state of affairs obtains.) That the patient must sleep on his side and not on his back, on a hard mattress, with not too heavy covering, must avoid promiscuous company, obscene literature, and must fight against lascivious thoughts, I will merely mention, as this is known even to the layman.

In nocturnal pollutions unaccompanied by any sensation, and in diurnal pollutions, not due to any local or spinal irritation, strychnine is indicated. While I start with small doses — 1-100 grain — I sometimes run up as

high as 1-12 grain three times a day. I often combine it with hydrastine and ergotin, as in the following formula:

℞ Strychninae sulph. .... gr. 1-30
Hydrastinae hydrochlor. .... gr. 1-4
Ergotini .... gr. ii

M.f. caps. No. 1. D. tal. dos. No. lx.

Sig.: Caps. un. bis vel ter in die p.c.

Instead of hydrastine I now often prescribe styptol or stypticin in 1 grain doses.

Cold water ablutions of the perineal region are very useful and the benefit derived from them is often immediate. Instead of plain water I have been prescribing for the last eighteen years the following:

℞ I. Etheris acetici......... ℥ i ss
Ol. rosmarini.......... ʒ ii
Ol. origani............. ʒ ii

℞ II. Ammonii chloridi ..... ℥ viii

Sig.: Put teaspoonful of the liquid and tablespoonful of the powder in small basinful (1 pt.) of water and wash with sponge as directed, before going to bed (or night and morning).

I find that the ablution with this solution has a much more beneficial effect — both psychic and physical — and is performed more faithfully than is the case when water alone is ordered. The liquid medicine — at least the first two ingredients — were suggested to me by Prof. Fürbringer of Berlin, who is probably our best authority on the treatment of sexual diseases. In some cases where a strong stimulant effect is desired, I replace the oil of rosemary with oil of turpentine.

For the weakness, sometimes intolerable, of the neck

and spine muscles, so often complained of by the sufferers from pollutions and spermatorrhea, we have three remedies: (1) Plastering the entire back with adhesive (or capsicum, or capsicum and belladonna) plaster, leaving on for five to ten days; (2) electricity; and (3) painting at night, or night and morning, with the following mixture:

℞ Chloroformi .... ℥ i
Tr. capsici .... ʒ ii
Tr. belladonnae .... ʒ vi

Paint quickly a few times with camel's hair brush.

This mixture smarts pretty strongly for a minute or two, but the effects from its use will be a revelation to many physicians. Do not paint it over the entire length of the spine; use the upper third at the first application, second third at second application, etc., and then start over again from the neck. In this way no soreness is ever produced. As I said before, the relief of the muscular weakness and the general tonic effect on the entire system from this mixture, are quite remarkable.

But important as the moral and general treatment is, it is but adjuvant to the local treatment — urethral and rectal — which is most important, and in most cases indispensable.

Local Treatment. We now come to the local treatment. As we stated before, the prostatic portion of the urethra is exquisitely sensitive in the vast majority of cases, being responsible for a large share of the symptoms. Our first endeavor must therefore be to diminish this sensitiveness. Steel sounds, or better still, Kollmann's dilators, are excellent for this purpose, but their introduction is, per se, so painful, and creates such spasm, that we are often unable to use them without the employment of a local anesthetic.

Cocaine is, of course, sure and positive in its effects; its use, however, is so often accompanied by disagreeable or even dangerous by-effects, especially when used in the urethra, that I have practically given up its use and employ some of its substitutes, generally eucaine or alypin.

I believe that instead of subjecting the urethra to repeated local anesthetizations, we can do better if we "harden" the urethra so that it loses its sensitiveness, and we are enabled to pass sounds without the necessity of local anesthesia. The best substance for "hardening"— diminishing the sensitiveness of the urethra — is and remains silver nitrate. But in its use I differ from the majority of my confrères. The usual method of instilling 10, 20 and even 50 per cent solutions I consider cruel, brutal and injurious. The reaction is often excessively severe, and I have seen excruciating pain, bloody discharge and complete retention of urine resulting from them. I use the nitrate of silver differently.

I usually start with a 1 to 5,000 and sometimes even with a 1 to 10,000 solution. I insert a soft-rubber return catheter (Mitchell, or one with several perforations throughout its upper two inches) almost to the neck of the bladder (or within an inch from it) and inject from two to eight drams of the above solution. In this strength the silver nitrate causes no pain, no strangury, no disagreeable symptoms of any kind. Gradually I increase the strength to a 1 in 3,000, 2,000, 1,000, and finally 500. It is seldom necessary to go above that. When the patient reaches this strength, all the congestion, sensitiveness and irritability of the urethral canal are generally cured. And not infrequently his trouble, for which he came to be

treated, is cured too. We are now able to employ, if necessary, further mechanical manipulations, which then call forth little reaction. The urethral canal has lost its sensitiveness and can be handled much more easily than without the preliminary silver nitrate treatment. Where, however, there is a localized inflammation of the posterior urethra, where the colliculus seminalis is hypertrophied and inflamed, there we must use stronger solutions. These solutions ranging in strength from two to ten per cent are best applied by the means of a Guyon syringe, one to three drops being sufficient for an instillation. Or they may be applied on a cotton swab thru the endoscope. Where the colliculus seminalis is distinctly seen to be the sole part affected it may be cauterized with a 20 per cent solution. But some very unpleasant after-effects sometimes make their appearance after such a cauterization, namely: severe strangury and dysuria, hemorrhage, complete retention, etc. Generally speaking, the very strong solutions of silver nitrate, or the galvano-cautery, are to be reserved for exceptional cases only.

The Use of Sounds or Dilators. As stated above, the treatment with steel sounds or dilators once or twice a week is very useful; I will say, however, that the usual treatment — leaving in the sound for two to five minutes seems to me of little value. I always leave in the sound or dilator for ten to twenty minutes and sometimes for a full half hour. While in the treatment of strictures the urethral dilators are in every respect superior to the sounds, in the treatment of the conditions I am speaking of, I prefer the latter to the former. Still, even here the dilator has this advantage: We can introduce it through a

meatus which will not admit anything larger than 18 French. (And when in the urethra we can, of course, dilate the blades as far as we want to.) While if we want to use sounds and have to deal with a narrow meatus, we must perform meatotomy.

Besides the sound and the dilator, we have the psychrophore or cold-water urethral sound and the ice-water rectal tube. The latter is particularly useful, as it can be used twice or three times a day by the patient himself and without any fear of irritation or infection. I might add here, in parentheses, that in cases requiring long and persistent treatment, I take the patient into my confidence, invoke his aid, make him, so to say, an assistant of mine. It is only thus that success is possible in many cases. It is impossible to expect a patient to come every day, twice a day, or even every other day for treatment. If you teach him to do certain things for himself, the course of the treatment will be materially shortened. Of course you must be sure that your patient is intelligent and has a clear perception of the dangers of infection, a wholesome fear of them and knows the meaning of surgical cleanliness.

Some Local Applications. Several local applications have been doing good service in my hands in the treatment of the various forms of sexual weakness. One of them is a combination of strychnine and hydrastine and has the following composition:

℞ Strychninae sulph. .... gr. 1
Hydrastinae hydrochl. .... gr. x
Aquae destill. .... gtt. 400

One drop of this contains 1-400 grain of strychnine and 1-40 grain of hydrastine. By the aid of a Guyon,

Ultzmann or a Record endourethral syringe one to four drops is deposited in the prostatic urethra. Another combination is:

℞ Hydrastinae hydrochlor. .... gr. x
Ergotini .... ʒ i
Aquae .... gtt. 600

Dissolve and filter. Dose, three to ten drops endourethrally.

Instead of hydrastine, hyrastinine may be employed in the above two formulas, with equally good results.

Still another combination is:

℞ Strychninae sulph. .... gr. 1-4
Hydrastininæ hydrochlor. .... gr. v
Sol. adrenalini chlor. (1:1000) gtt. 100

Dose, one to four minims endourethrally.

I do not care to go into any discussion as to whether strychnine applied locally can produce any effect. Nor will I try to contradict those who claim that the beneficial effects of the strychnine-hydrastine solutions are purely psychic. In my hands these solutions have proved distinctly beneficial and I am using them every day. And one little fact with me outweighs a whole lot of theoretical considerations. If the theory is contrary to the facts, so much the worse for the theory.

By the aid of the local treatment outlined in this chapter, combined with the general treatment, both of course used conscientiously and with discrimination, the vast majority of cases of pollutions and spermatorrhea will be cured, while no case can fail to be materially benefited. But, risking reiteration, we must emphasize that no case can be treated by a set formula; every case must be studied by itself — and treated by itself.

CHAPTER TWENTY-ONE

BROMIDES AND MARRIAGE AS A PANACEA IN POLLUTIONS AND SPERMATORRHEA

Before dismissing the subject of the treatment of pollutions, I must say that the treatment by bromides and other sedatives is merely a makeshift, a makeshift that is often ineffective, and often effective but injurious, and sometimes the more injurious the more effective it is. I will make my meaning perfectly clear. The point is of such importance that it deserves a little discussion.

Modern scientific medicine differs from the old empiric jumble of our ancestors in that it teaches the importance of removing the cause of the disease wherever possible, instead of treating the mere symptoms. In the treatment of plethoric pollutions we seem to forget this principle. What is the cause of pollutions in a strong, healthy man? Simply failure to satisfy a normal, natural instinct. It is normal, natural and necessary for a robust adult to have occasional sexual intercourse. And if a man of 25 or 30 comes to us and tells us that he has been suffering with pollutions, because he hasn't had any sexual intercourse, the proper, honest and scientific thing to do is to tell him to go and have intercourse. Instead of that, we begin to depress his sexual activity and lower his general vitality by injurious drugs. We do not act in this manner in any other human disorder. If a person comes to us with severe headaches, and we find that the cause of the head-

aches is lack of fresh air or deficient action of the kidneys, we do not — that is, if we are physicians worthy of the name — stuff the patient with headache powders, but we advise him to get plenty of fresh air or we try to increase the activity of the kidneys. If a patient has a painful gnawing sensation in the stomach because he doesn't eat enough we do not attempt to dull that pain by morphine or other narcotics, but advise the patient to eat. And so, in many cases of nocturnal pollutions the only *honest* advice we can give the patient is to have normal sexual relations, and as soon as he follows the advice, the trouble, i.e., the pollutions, disappears.

But let us bear in mind one thing: the advice to have sexual relations may be given only in the stage of strong, plethoric, "physiologic" pollutions. To give this advice in the stage of atonic pollutions, or in the stage of spermatorrhea, is folly, and if the advice is to get married, then the folly becomes criminal folly. I have seen too many sad tragedies resulting from this thoughtless advice. A patient feels he is becoming physically and mentally weakened from excessive nocturnal or diurnal pollutions. He consults his family physician. He gets a prescription for some bromides, or bromides and lupulin; he takes it for a time with the only results that he gets pimples and a disordered stomach. The pollutions keep up the same way or become worse. He again consults the physician. "Well, I can do nothing for you; the only thing for you to do is to get married."

The man has already somebody in view, or he looks around and finds somebody. He may have no inclination to get married, his plans might have been entirely differ-

ent ones, but as his life and health depend upon it, he gets married. And he finds that he is impotent. And the pollutions may not stop either. And here the physical condition combined with the agony and humiliation of not being able to satisfy his wife, may throw him into the deepest slough of despond; may convert him quickly into the worst type of sexual neurasthenic. And we have a disrupted home or suicide. Many of the cases of suicide immediately or soon after marriage, of which we read in the newspapers, are of this character. If we are to advise a man suffering with pollutions to attempt intercourse, then we should advise him to have illicit intercourse — and I say this without hesitation, all the tenth or fourteenth-century obscurantists to the contrary notwithstanding. If such a man attempts intercourse with a prostitute or a lady friend and he finds himself relatively or completely impotent, then no damage is done. The man has suffered a fiasco, he knows he must treat himself and that's all there is to it. But if, following the pernicious advice of a thoughtless or incompetent physician, he gets married, the mischief is done and it cannot be undone so easily, if at all.

It is almost incredible how careless — or is it real ignorance? — many physicians are on this point. I feel deeply on the subject, because I see the tragedies only too frequently. Only this week a physician came to consult me. He was suffering with almost nightly atonic pollutions, and either as a result of these or independently of them, with severe gastro-intestinal disturbances. The specialist who treated him for the latter urgently advised him to get married. He told him he could not get well

unless he did get married. The doctor felt, that it would perhaps be a risky thing, and came to get my opinion. He is 36 years old and has never had intercourse in his life. That fact alone is suspicious. An examination showed the penis and testicles small and shrunken, in fact infantile in size, and this with several other points in his history, left me no choice but to put an emphatic veto on any thought of marriage at the present time. It may require two or three years of very complex treatment — hygienic, general and local — before he may permit himself to entertain any matrimonial thoughts. This case is not by any means unique. I know even of cases where the patient told the doctor that he attempted intercourse and found himself completely impotent — he was either unable to get an erection or the ejaculation was instantaneous, and nevertheless the doctor's advice was: "get married."

The woman in the case is not taken into consideration at all, as if she was not a living human being at all, but an inanimate object, a mere vessel. Leaving out the immorality and the cruelty of the advice — for one must be callous indeed not to think of the prospective wife's wretched possibilities, that she may become a worse sufferer than the husband — it is time for the profession to become aware of the fact, that marriage is not a panacea for all sexual disorders, that in itself it will not restore all sexual cripples to health and vigor, but on the contrary it is apt to render them worse. The cripples must first be cured, or practically cured, before they may be advised or even permitted to marry.

It is just as criminal to advise a man suffering with

atonic pollutions or spermatorrhea to marry as it would be to do so in the acute stage of gonorrhea or syphilis.

I have stated that the treatment by bromides is often ineffective, often injurious, and sometimes the more injurious the more effective it is. That the bromides are often ineffective is known to everybody. Sometimes in spite of frequent and constantly increasing doses the pollutions go on just the same, or they even increase in frequency, tho they generally diminish in intensity. In other cases the bromides are effective. That is, the patient under their administration ceases to have pollutions. Is this accomplished without injury to the patient's general and sexual system? In many cases, yes. The bromides seem to depress the sexual function just sufficiently to rid the patient of a too frequent repetition of the pollutions. No damage *seems* to result, for when such patients decide to assume or to resume sexual relations, they find their power unimpaired. In other cases, however, the result of the bromides is very disastrous. The pollutions become very rare or cease altogether. But they exchange their pollutions for something much more serious: They become temporarily or permanently, relatively or completely, impotent. Entirely too dear a price to pay. These are not theoretical consideration or imaginary fears. I am used to weighing evidence, to being skeptical about patients' assertions and guarding against the *post hoc propter hoc* fallacy. And I can assert positively, after eliminating all doubtful cases, that I have seen a considerable number of cases in which the impotence could be traced positively to the use — or abuse, if

you will — of the bromides, particularly the bromide of potassium.

The bromides and marriage are very dangerous remedies to prescribe in sexual disorders. They must be used with the greatest care and discrimination. They are more dangerous than morphine or atropine. And in the hands of the injudicious they are sure to bring pain and disaster.

Note to Second Edition: I note in to-day's (April 15) papers the following news item:

NEWLY MARRIED; KILLS HIMSELF.

Philadelphia, April 14.—Howard S. Ludwig, 32, a local real estate dealer, who was married in Newark on Saturday to Miss Violet Richardson, who is now at Wenona, N. J., shot himself through the temple at the Broad street station to-day. He is said to be dying. Despondency is said to have prompted the act.

Such items are quite frequent. And to me they have practically one meaning. When a man commits suicide the day after, or several days after, his wedding, it generally means that he found himself impotent. He is probably also a neurasthenic and the chagrin and humiliation is more than his weakened nervous system can stand.

PART III

SEXUAL IMPOTENCE IN THE MALE

CHAPTER TWENTY-TWO

THE CAUSES OF IMPOTENCE

I have never subscribed fully to the Latin maxim, *Qui bene diagnoscit, bene curat* — he who diagnosticates well, cures well. For unfortunately there are only too many cases where the diagnosis is perfectly obvious, while the method of treatment leaves very much to be desired. Nevertheless none will dispute the statement that of two men equally proficient in treatment, the better diagnostician will have the larger percentage of successes.

Probably in no class of cases is the ascertainment of the underlying cause of the trouble so important as it is in the sad affliction which is designated as sexual impotence. Very often the mere finding of the cause is more than half of the battle won. The causes being very numerous and complex, great patience and judgment are required in taking the patient's history, and in no other class of diseases is the patient's complete confidence so absolutely necessary as it is here. And without it we are often helpless.

The causes of impotence are as follows:

Masturbation. This is a very common cause, because, as I have stated before, practically every human male begins his sexual life with masturbation. And while the habit, if commenced fairly late and practiced moderately, in the majority of cases leaves no ill effects, there is no question that if commenced at the age of ten, twelve or

fourteen and indulged in immoderately, it may lead to relative or complete impotence, temporary or permanent.

Pollutions. What we said about masturbation applies with equal force to pollutions. Pollutions of rare occurrence or of moderate frequency are harmless. But if frequent and long continued they may ultimately lead to impotence.

Spermatorrhea. We do not meet frequently with cases of true spermatorrhea, but when we do, we generally also have to deal with relative or complete impotence. And very often spermatorrhea and impotence are twin phenomena in sexual neurasthenia.

Prostatic Congestion. An inflamed or congested prostate is often the cause of impotence, but not invariably so. On the contrary, in some cases an inflamed and irritable prostate may lead to an increased libido sexualis, and apparently also to more vigorous erections. But only for a time. Eventually a pathologic prostate leads to relative or complete impotence.

Urethral Congestion. Congestion of the prostatic urethra is a frequent and well-established cause of sexual impotence. The hypersensitiveness of the urethral mucous membrane is sometimes exquisite, and renders an erection impossible or imperfect and ejaculation premature. The most common cause of such urethral congestion is a severe chronic gonorrhea, but it may be due to masturbation, prolonged abstinence, etc.

Gonorrhea. Gonorrhea, as already mentioned, is one of the great causes of sexual impotence, ranging probably next to masturbation in this respect; not, however, gonorrhea, by itself, directly, but by its sequelae. Just as by its

causing epidydimitis and orchitis it is one of the principal factors of sterility or of impotentia generandi, so by its causing congestion of the posterior urethra, prostatitis, etc., it is one of the principal factors in relative sexual impotence and ejaculatio praecox.

Stricture. This sequel of gonorrhea plays a decided rôle in causing relative sexual impotence, that is, imperfect erections and premature ejaculations. The causative relationship between stricture and impotence cannot, in my opinion, be the subject of any doubt, for the result of the treatment of stricture and the improvement in the potency is so marked and has been noticed by me so frequently, that to speak of a mere coincidence would be absurd. Many patients *know* the beneficial effects of passing a sound, and they claim that dilatation of their stricture is invariably followed by improvement in their sexual power.

Narrow Meatus. By some of the older writers a very narrow meatus was considered as one of the causes of impotence, relative or even complete. I have never seen an instance where this could be considered a causative factor, but I have seen a number of instances where a narrow meatus was cut liberally with deleterious effect on the potency, just as we often see cases where a free meatotomy has an injurious effect on the force and regularity of the urinary stream.

Organic Causes. There are certain organic conditions of the penis and testes which render intercourse either physically impossible or very difficult, or at least unsatisfactory. But most of those conditions are of a purely academic or theoretical interest; they are so rare that a physician may

not see a case during his entire practice. Such, for instance, are: congenital absence of the penis or its loss from ulceration; hypertrophy of the penis, its size being so large that it cannot be introduced into any vagina; double penis; bifid, or split, penis; webbed penis, where the organ is united to the scrotum; tumors; plastic exudations; torsion, where the penis is twisted or bent in a vicious direction, so that intromission is difficult or impossible; hermaphroditism; fracture, and various other conditions. *Epispadias,* or the condition in which the urethra opens on the upper surface of the penis, and *hypospadias,* where the opening is on the under surface, are usually, but not necessarily, accompanied by impotence: it depends a good deal on the extent and the location of the defect. Where a good deal of tissue is lacking either in the corpora cavernosa or in the corpus spongiosum, no erection is possible. The relation of these two anomalies to impregnation will be mentioned in the section on sterility.

Abnormalities of the Testes. Complete congenital absence of the testes is of course accompanied by lack of libido and lack of potentia, both of coeundi and of generandi. As a general rule this is also true of cryptorchids, where both testes are in the abdominal cavity. This rule, however, has decided exceptions. In Prof. Lang's clinic, in Vienna, I saw a young cryptorchid who had powerful erections and perfect potentia coeundi. He was in the clinic for multiple chancres — two on the penis and one on the abdomen — which he had contracted in regular intercourse. Monorchids often are sterile, but all the individuals encountered in my practice were sexually potent. They came for treatment because they and their

wives wanted children, and not because they had any complaint about their potency.

Atrophy of the Testes. When atrophy of the testes is caused by a general constitutional or by local disease, or by masturbation or sexual excess, it is accompanied by loss of libido and by impotence. But this is not invariably true when the testes are lost through accident or castration. As a general thing, loss of the testes does lead to complete impotence, but there are numerous exceptions. And the usually prevalent opinion that eunuchs are incapable of sexual intercourse has been shown to be erroneous. Some castrates are very powerful in this respect. They have strong erections and "seminal" emissions, the emissions in such cases coming principally from the prostate gland. It must be borne in mind that the prostate gland is an important sexual organ, and plays an important rôle in the sexual act. Its rôle has been underestimated too long.

Neuralgia of the Testes, of the spermatic cord, of the urethra, of the neck of the bladder may be a causative factor in deficient erections or in premature ejaculation. But it is a rare condition, and, as a rule, readily curable.

Hydrocele. If excessive, this may become a mechanical cause of impotentia coeundi. If long continued, it may cause atrophy of one or both testicles, and thus be also the indirect cause of loss of libido and of potentia generandi. Fortunately the condition of hydrocele is easily removed.

Hernia. A scrotal hernia may be and often is a mechanical cause of impotence. The penis is not sufficiently large to protrude, so to say, above the scrotal mass. The

testicles may also be injured, as in the case of a large hydrocele.

Varicocele. In the mind of the laity, the relationship between varicocele and impotence is well established; this opinion has been fostered by the quacks, who diagnose varicocele, whether it exists or not, and who advise an operation for this affection as a cure for all ills of a sexual nature. We are not so sure of this causal relationship. We do not deny that it may exist, but we have not been able to assure ourselves of it. We have seen men with varicocele who were impotent, we have seen men with varicocele who were perfectly normal sexually, and we have seen men with varicocele who had an abnormally strong libido and potentia. I have, of course, seen cases where an operation for varicocele resulted in the cure of impotence, but my impression was that the impotence in those instances was purely psychic, and in psychic impotence any procedure which impresses the patient may result in a cure. Where the varicocele, however, is well pronounced and extreme, it may, by establishing a vicious circle, be the cause of impotence, and should be removed before other treatment is attempted.

Diseases of the Prostate Gland. Any abnormality of the prostate, such as hypertrophy, prostatitis, is apt to lead to sexual impotence. In prostatitis, the same as in prostatic congestion, mentioned at the beginning of the chapter, it is usually temporary, and relief of the prostatic condition removes the impotence. It is well to bear in mind that in prostatic trouble, diminished sexual power or premature ejaculation may exist simultaneously with an increased libido.

Atrophy of the Prostate Gland. This condition is rare and it cannot be considered alone a cause of impotence; for the prostatic atrophy is generally accompanied with general atrophy of the genital organs.

Phimosis and preputial calculi may be serious hindrances to the proper performance of the sexual act. They are a frequent cause of premature ejaculations. I mentioned preputial calculi. Sometimes it is not calculi, but just dirt, and the amount of it under some prepuces is simply incredible.

I treated, not long ago, a bookkeeper, thirty-nine years of age, who had recently married and found that he was not in a fit condition. Intercourse was painful and ejaculations premature. The conglomeration revealed on retracting the prepuce, as well as the odor, was something frightful. He told me that never in his life had he retracted his prepuce once! He didn't think it was either necessary or possible to do it. Besides — he taught a class in a Sunday school — he considered it sinful to bother with his genitals. He was chaste and clean until his wedding day (chaste, yes; but clean — certainly not!). The mere removal of the preputial concretions ameliorated his condition considerably. Cleanliness about the genitals, either in the male or in the female is not yet so universal as it should be.

Age. This is, of course, a very important factor, for all men become impotent if they only live long enough. But if we attempt to answer the question, at what age do men become impotent, at what age is impotence physiologic, normal, we find we cannot do so; for, in the sexual

sphere more, perhaps, than anywhere else, is each man a law unto himself.

In many men the sexual power begins to decline at the age of 40 and becomes extinguished at the age of 50. Many men are just as powerful at 50 and 55 as they were at 30, while not an insignificant percentage remain perfectly potent and ardent at the age of 65, 75, and later. I have had a patient who had his first gonorrhea at the age of 68! Since the death of his wife, three years previously, he had been indulging in masturbation and illicit intercourse. He wanted to be cured of his gonorrhea, because he decided to get married. He assured me that not only could he indulge in intercourse nightly, but that the desire to do so was very great — irresistible.

There is also a class of cases which I have not seen referred to anywhere, but which are interesting from a physiologic point of view. I refer to men who become sexually stronger after the age of 40 or so. I have known several men who assured me with absolute positiveness that their sexual power — duration of the erection, ability to repeat the act — was considerably stronger at 45 than at 35 or at any previous age. As this statement generally comes from married men, it is possible that their improved sexual condition was due to their giving up coitus interruptus.

Sexual Excess. Sexual excess may, per se, be a cause of impotence. Every physician who has sexual diseases to treat can testify to that. I have now the following case under treatment: Patient, X. Y., 25 years old, in perfect health in every respect. Led a model life. He masturbated only moderately for a period of three or four

years; suffered with occasional pollutions (about once a month). Had had no intercourse until his marriage, six months ago. Indulged immoderately, six to eight times in twenty-four hours. After two months of this honeymoon orgy he began to notice a decline both in libido, and in strength and duration of erections. But instead of giving his system a rest, he kept right up, incited to the excesses by his wife. In another month he lost all desire and was unable to get an erection. Apparently both the erection and the ejaculation centers were completely exhausted.

Fortunately in almost all such cases the impotence is only temporary, though the former vigor may never be regained. As a rule complete sexual rest, with proper tonic treatment, brings about the desired result. But while this is true of adults, it is not true when the victims of sexual excess are boys. In them the impotence may become permanent. I know of cases of very young boys (eight, ten, twelve, and fourteen) who had been seduced by vicious servant maids and nurses and forced to perform the act the best way they could several times a day. Some of these victims never recovered, remaining impotent for life.

Nothing injures the sexual apparatus so much as its premature abuse. The excess that will in the adult cause but little or only temporary damage will in boys cause terrible and sometimes permanent havoc.

Sexual Abstinence. I am firmly convinced that continued complete abstinence from any sexual gratification may result in partial or complete, temporary or permanent, impotence. I am well aware of the fact that some societies have even passed resolutions to the effect that inter-

course was unnecessary to perfect health. But to this I will reply that one positive testimony counts for more than one hundred negative testimonies. If a hundred physicians have not seen any impotence resulting from abstinence, then it is their good luck or their misfortune. It may be simply an accident in their practice, and their testimony cannot go far in comparison with the testimony of physicians who have seen cases of impotence for which they could find no other etiologic factor than that of abstinence. I could give several cases from my practice, but two will suffice.

Case 1 is that of a physician 35 years of age. He practiced intercourse moderately between the ages of 18 and 24, and his sexual power was normal. At the latter age fear of venereal infection, mixed with suddenly arisen moral scruples, determined him not to indulge any more until he married. The struggle to overcome his desire was a hard one, but became gradually easier. He would have occasional emissions accompanied with strong erections; but gradually the latter became weaker and the former rarer, until sexual matters almost completely ceased to bother him. If he had a desire or if a lascivious picture presented itself to his mind, he suppressed it ruthlessly by a strong effort of the will. At the age of 34 he became acquainted with a young lady whom he was very anxious to marry. But before broaching the subject at all he decided to test his virility. The test resulted in complete failure. He made several attempts with public and semipublic women, but in each case he failed miserably. He could neither get up a desire nor an erection. He is improving under energetic treatment, but it is questionable whether

he will ever regain his full vigor, for both the penis and testicles show quite some atrophy.

Case 2 is that of a drug manufacturer, 38 years of age. He is not only a pious but a sincerely religious man, and he considered extramarital intercourse a heinous sin. His passions were very strong, but he never masturbated; he suffered from moderate pollutions accompanied with powerful erections. The erections became gradually weaker, but the pollutions did not increase in frequency. At the age of 38 he decided to get married and came to consult me as to his virility. The sexual organs showed no abnormality, no atrophy. I told him that in a case like his, where he had had no erection, practically, for years, it was a risky matter to pronounce an opinion and that a positive decision could be arrived at by a test only. This, of course, a religious man such as he could not think of doing. He married, and another terrible domestic tragedy (the wife is only 24) has been added to the already fearfully long list. He is completely impotent as far as performance is concerned, though he is not lacking in desire.

Nature does not allow us to trifle with her. She does not permit any organ to remain inactive, any function to lie fallow for years without meting out punishment; the organ atrophies more or less and the function is weakened or destroyed.

As to those resolutions passed by some societies to the effect that intercourse is unnecessary and abstinence perfectly harmless, I regret to say that all such resolutions have so far been passed by societies that are tinged or fully impregnated with religious or moral bias. They have not been passed by calm, scientific investigators;

they have been passed by good but rather narrow men and women, with a certain object in view, for a certain purpose. That purpose has been to decrease the immorality of licentiousness, that is to say, the sin of illicit intercourse, and to guard the young men from the dangers of venereal disease. But while the purpose, being both moral and hygienic in character, is a laudable one, I maintain that the statement that intercourse is entirely unnecessary for one's perfect health (note that some of the resolutions have it that *illicit* intercourse is unnecessary—just as if nature made a difference between licit and illicit, between legal and illegal) is a falsehood, and that moralists and theologians have no right to sail in the garb of unbiased scientists.

As to the danger of venereal disease, it is a reality and the contraction of venereal disease is a great misfortune. But I will here repeat the words of a physician friend, words which I do not subscribe to, but which give some food for thought. Said this physician friend: "I would rather have our young men run the risk of venereal infection than have them become confirmed masturbators and impotent." These words acquire special weight nowadays, when the venereal prophylactics in our possession reduce the danger of venereal infection to nothing, or to a negligible quantity.

And I will add this: A wife can be protected against her husband who has had a gonorrhea; nothing can be done for her with a husband who is permanently impotent.

Coitus Interruptus vel Reservatus. The abominable practice of withdrawal or interrupting coitus just when an ejaculation is about to take place and when

both parties are at the highest point of tension is one of the poisonous fruits of human civilization. Though not unknown in ancient times, and even mentioned in the Bible, it is only within the last quarter of a century or so that it has come into widespread use. The modern husband and wife, deeply feeling the responsibilities of bringing into the world more children than they can properly bring up, frequently make use of some method of prevention of conception. But this method, besides being unsafe, that is to say, uncertain, is one of the most injurious methods imaginable. It is responsible for numberless cases of melancholia and neurasthenia and is an *undoubted* cause of impotence. As a rule the impotence is only partial, expressing itself in imperfect erections, in premature or retarded ejaculations; but so far as libido is concerned, it may be completely absent. In fact, the man may develop a disgust for intercourse.

In this connection a word may be said about condoms. Their use sometimes is injurious so far as libido is concerned, but the cases in which they affect virility are very rare. So far as ejaculations are concerned, they are usually retarded rather than accelerated. (See Coitus Condomatus.)

Marital Dislike. It is a sad fact to chronicle, but being a fact it must be chronicled. Certain cases of impotence are due exclusively to the man's dislike for or indifference to his wife. And the impotence makes itself evident only toward the wife; with other women the man may be perfectly potent. If such cases were frequent, monogamy as an institution would have a hard time of it. Fortunately uncomplicated "marital impotence" is rather rare.

Drugs. A number of drugs are reputed to have a ruinous effect on man's sexual power and to lead ultimately to impotence. Those drugs are opium and morphine, cocaine, arsenic, tobacco, chloral, the bromides, and potassium nitrate. There is one drug that I have not seen mentioned anywhere, but of whose power to cause, ultimately, sexual debility I am firmly convinced. That drug, strange as it may seem, is strychnine. I myself hesitated to accept this drug into the category of sexual depressants, but several facts left me no choice. I have treated a number of patients who were given by their former physicians strychnine for sexual weakness; and in a very large percentage of cases the story told was the same. At first, on taking the medicine, they felt better and stronger; the erections were firmer and the desire was more frequent, but on continuing the use of the drug and perhaps increasing the dose, the condition became worse. This history was given by too many patients to be accounted for merely as a coincidence.

In medicine we must be very careful not to mistake *post hoc* for *propter hoc,* not to confound a sequence with a consequence; still, when we see the same phenomenon repeated in a number of cases we have a right to draw tentative conclusions at least. As strychnine may do great harm in paralysis, so it may do injury in sexual debility; by irritating the already irritated erection and ejaculation-centers, it causes their exhaustion and thus makes bad matters worse.

As to tobacco, I cannot speak from personal knowledge. The statement is generally made that excessive use of tobacco causes sexual impotence. I have not seen such in-

stances; I have seen excessive smokers who were impotent, but in them the excessive consumption of tobacco went hand in hand with the excessive consumption of alcohol, and so it was impossible to decide which agent was more to blame. Morphine and cocaine in small doses stimulate the sexual desire, but that chronic morphinists and cocainists are impotent is well known. The same is probably true of the habitual use of cannabis indica.

As to the injurious effects of the bromides, particularly potassium bromide, I have seen some very sad cases. Some high-minded young men, considering extramarital intercourse morally wrong, decided to repress their sexual desires by the use of potassium bromide. At the advice of a young physician, they took 30 to 60 grains (2 to 4 grams) every night for a period of several months. Two of the young men kept up the bromide, with some intermissions, for over two years. Most of them succeeded in repressing, in suppressing their desires. But, unfortunately, they also succeeded in several other things: they succeeded in ruining their digestion, in getting a nice crop of bromide-acne that was very resistant to treatment, and in becoming impotent. I succeeded in restoring their potency to a greater or lesser extent, but one is still under treatment and there is a possibility that his deplorable condition may be permanent. In that case this conscientious, fine young fellow will, of course, give up the girl he loves and will have to vow himself to life-long celibacy.

Constitutional Diseases. There are a number of constitutional diseases which may result directly or indirectly in partial or complete sexual impotence. Those diseases are diabetes, leukemia, myxedema, Addison's disease, per-

nicious anemia, locomotor ataxia, various forms of myelitis, tumors and injuries of the brain and of the spinal cord, and a few other conditions.

This part of the subject, however, is of relatively little interest to us, because the original disease is so much more important than the impotence, which latter, under these circumstances, becomes a mere unit in a great symptom-complex that completely overshadows it; and both patient and physician are satisfied to leave the impotence alone, and to devote their energies to the life-threatening malady.

Typhoid fever, diphtheria, erysipelas and malaria are sometimes followed by impotence. I have seen one case of impotence following typhoid fever, which resisted all treatment. The typhoid fever had been in that case very severe, the emaciation was extreme, and there was great atrophy of the testicles, these being reduced almost to the size of two beans. In convalescence from typhoid and from other diseases there is, however, not infrequently, a great increase in the libido sexualis (see next paragraph).

Tuberculosis. While there are some cases of impotence due to tuberculosis, the fact remains that in the majority of cases this disease has the contrary effect, increasing the sexual desire enormously, and, not so infrequently, the sexual power. Whether this sexual erethism is due to some toxin circulating in the blood, or whether the excessive sexual indulgence results from the patient's staying at home, doing nothing and partaking of tonics and nutritious food, the fact of excessive indulgence of tubercular patients is well established. In their egotism and erethism they become burdensome to their wives and ruinous to themselves. There are cases on record where consump-

tive patients had intercourse (with their poor wives, of course — they have to stand everything) on the night preceding their demise.

I have had a married tubercular patient who, besides abusing his wife to the limit of her endurance, consorted frequently with street-women, until he became infected with syphilis, for which disease he came to me to be treated.

Obesity. Obesity as a cause of impotence, has been questioned by some physicians. I have not the slightest doubt of the direct causal connection. When the obesity is very rapid in its onset, the impotence may be complete; and treatment which reduces the obesity at the same time brings back the potency. The rationale of this causal relationship is hard to explain.

Alcoholism. That alcohol acts as an excitant to the sexual appetite is well known; but its action on the power is variable, depending on the quantity consumed and the form. Small amounts often act beneficially, large quantities act detrimentally, sometimes preventing erection altogether. As to the form, beer is the most injurious. As to chronic alcoholism, its effects are almost invariably pernicious, and many chronic alcoholists are completely and hopelessly impotent.

Worry. I consider this one of the most important factors in sexual impotence. That great and continuous worry will diminish or abolish one's sexual desire more than anything else will, is a well-known fact. It is not so well known, however, that it may also induce relative or complete impotence, and what is more, the impotence may be permanent. In most cases, however, it passes away gradually, after the cause has disappeared. But it may

require many attempts, considerable sexual education, before the potentia is brought back to its former condition.

Fright. Severe fright sometimes acts as a cause of temporary impotence, but only fright having some connection with the sexual act. We know of an instance where a man was interrupted in the act, by the husband of the woman and several detectives who broke in the door, and he was practically impotent for nearly a year. Each time when on the point of performing the act the fateful night would come to his mind and the partial erection would promptly subside.

Intellectual Pursuits. Nature resents burning the candle at both ends, and it is very rare that people who devote all their time to severe intellectual work do not pay for it by sexual weakness or impotence. This refers to purely intellectual work — mathematics, science, research, philosophy, and so on. Particularly is it apt to attack those who are engrossed body and soul in certain "problems." The case is well known of a mathematician who, during each attempt at intercourse, would be disturbed by an abstruse mathematical problem and the attempt would fail. It was necessary to put him under the influence of alcohol before he could consummate the act. Another instance of the aid that Bacchus often renders Venus. A medical investigator told us that, while interested in a certain question which took away every minute of his spare time, he lost both desire and ability for over eighteen months. Pursuits that belong to the arts,— *belles lettres,* poetry, the dramatic art, sculpture, painting, and so on, have a rather opposite effect; they increase the sexual desire and perhaps also the sexual power.

Riding. Horseback and bicycle riding may aggravate

an existing prostatitis or a posterior urethral congestion, and thus may contribute to premature ejaculation. But it cannot be considered a direct, immediate factor of sexual impotence, and I consider the stories of officers having become impotent, as the result of long horseback rides, mere fables.

Automobile Riding. Fast automobile riding has recently been brought forward as a cause of impotence, and there are good grounds for believing that this is a real, and not a fanciful, cause. The jarring, the constant worry and anxiety which are inseparable from fast and furious automobile driving, induce a state of neurasthenia that is responsible for the impotence. The impotence is generally of a temporary character and yields to treatment at once, when the sport, or rather the furious speed, is given up.

Parotitis. The connection of the parotid glands with the testicles (and ovaries) is as well established as it is strange. That it may cause orchitis and epidydimitis, which may result in *sterility,* is well known. But I have not come across a single instance in which I could with certainty establish a connection between the impotence and the parotitis, as there were usually several other factors in these conditions which in themselves were sufficient to account for the impotence. I do not deny, however, that such causal relationship may exist.

There are a number of other causes which directly and indirectly influence the force of the erections and the ejaculations, etc.

Thus, for instance, gravel has a decidedly injurious effect, and is often the cause of ejaculatio praecox. The same is true of constipated people with full recta, where the feces press upon the prostate gland. I have had a num-

ber of such cases in my practice, where the mere device of cleansing the rectum by cold-water enemata produced a most rapid and favorable effect on the sexual act.

Intense libido is very frequently the cause of premature ejaculation. This intense libido is often manifested on the wedding night, when the couple have been long engaged. A word may be said here about long engagements as a causative factor in impotence. They are not only injurious, as being apt to cause intense libido — which is only a temporary trouble — but they may result in more or less permanent impotence, by virtue of the severe prostatic and posterior urethral congestion which they may cause.

The X-ray. Working with the x-ray without proper protection is liable to cause impotence, but the impotence is generally an impotentia generandi and not coeundi. At the present time we do not see such cases as often as we did at first, when we did not know the power of the x-ray in this direction.

Psychic and Mental Causes. That many psychic and mental phenomena may act as inhibitors of the sexual act is well known to everybody. We mentioned worry, frights, marital dislike as occasional causes of impotence. But this kind of impotence is usually of a temporary, transient character, and disappears with the removal of the cause. There is another kind of impotence, to which alone the term psychic impotence should be applied, where the patient without any apparent or discoverable cause, imagines, is afraid, suggests to himself that he is impotent and on account of this alone finds himself so. This variety of impotence will be discussed in a separate chapter.

CHAPTER TWENTY-THREE

THE PROPHYLAXIS OF SEXUAL IMPOTENCE

Alas! When the patients come to us for treatment, it is too late to speak of prophylaxis. It isn't lectures that they want on how they should have avoided becoming impotent. They want to get cured. But in no class of disorders is the adage: An ounce of prevention is better than a pound of cure, more true than it is in sexual impotence. And young men are beginning to appreciate the importance of a proper sexual life, and even when in perfect health, they now come to us asking for counsel and guidance; they want to know what pitfalls to avoid, in order not to get into sexual troubles of any kind. Fathers who are perhaps themselves victims of youthful indiscretions, who have suffered sexually through ignorance and secrecy which in their times surrounded every question connected with sex, are coming to us to learn how to watch over, protect, guide and instruct their children. A few words on the prophylaxis of impotence are therefore not out of place.

To prevent impotence, we must of course avoid or remove all the causes which cause impotence. We have seen that masturbation is one of the great causes of impotence, and we must use our utmost efforts to prevent or cure the masturbatory habit in our boys (see Section on Masturbation). If masturbation could be eliminated, a very large percentage of impotence would be prevented.

Nocturnal enuresis must be treated persistently, unflag-

gingly, until a cure has been established. To neglect it is criminal. Pollutions, if they show the slightest tendency to become too frequent or atonic in character, must be treated energetically. That diurnal pollutions and spermatorrhea must be treated goes without saying. Not to treat them is positively to open the door to impotence where it does not already exist.

Incompletely cured posterior gonorrhea is one of the somber factors in impotence, and the physician who treats gonorrheal patients has a great moral responsibility. The danger is not alone of leaving active or dormant gonococci which may in months or years to come infect and wreck the life of a healthy young wife; there is also a danger of leaving an uncured hyperemic patch in the posterior urethra, which may in time to come be *the direct cause of sexual impotence.* We must do everything in our power to change the public's and the medical profession's views about gonorrhea. We must impress upon everybody that gonorrhea on account of its complications and sequelae is an exceedingly serious disease and that the greatest care must be taken not to contract it. And if one has been unfortunate enough to contract it, he must be imbued with the seriousness of his trouble, and he must treat himself until, by every test at our disposal, he is pronounced cured. And the question comes up, whether in view of the seriousness of gonorrhea, we are not justified in instructing young men, who *cannot* or *will not* abstain, in the best and most efficient means of venereal prophylaxis.

Another important point is the question of continence. Believing as we do that in quite a large number of cases absolute continence is apt to lead to impotence, it is our

duty to permit, and in certain instances to advise and to urge the patient to have normal sexual relations. For in a certain percentage of cases this is the only way to avoid impotence and sexual neurasthenia. And I consider it necessary to emphasize that to advise continence in people past middle age is particularly laden with grave danger. Of course, sometimes we must do it, because it is the lesser of the two evils; but very often men of between fifty or sixty, or even forty-five, who have for some reason or other been continent for a year or two find their power completely if not irrevocably gone.

As in some cases we must advise against continence, so in others we must give a severe warning against sexual excess. While excessive *normal* sexual coitus does not lead to impotence as frequently as does masturbation or excessive pollutions, still cases of impotence from that cause are not so rare. We are apt to come across it particularly in newly married young men, who had been completely abstinent for a year or so before marriage; they often give full license to their pent-up passion, performing the act several times a day for days in succession, with the result, that after a while they become relatively or completely impotent. The impotence is generally temporary, but I have known cases where after some incredible excesses the condition of impotence became permanent. Any excess in middle age is also particularly dangerous.

And at every opportunity we must raise our voice against coitus interruptus as a fruitful cause of impotence.

If we could guard our boyhood and manhood against masturbation, pollutions and venereal infection, and if our social-economic conditions were such that all adults

if we find, as we usually do, a congested posterior urethra, we treat it with sounds, instillations of silver nitrate (2 to 5 per cent), instillations of hydrastine, internal administration of ergotin and styptol or stypticin, etc. Cold water sounds (psychrophores) are an important part of the treatment. If we find an enlarged and inflamed colliculus seminalis, we treat it the same way, or in exceptional cases we cauterize it with a 10 to 20 per cent solution of silver nitrate. But this must be left to the experienced operator only, for the reaction of this cauterization is sometimes very severe, causing strangury and retention for 8, 12 or even 24 hours. To guard against or to overcome this retention, we give good doses of sodium bromide and fluid extract of hyoscyamus, hyoscyamine, in doses of 1-60 grain; also large amounts of linseed tea and oil of santal or the various preparations of this oil (santyl, gonosan, etc.).

If we find an uncured posterior urethritis, or a granular patch, we must treat them according to well-known principles: silver nitrate instillations, irrigations or applications; touching the spot through the endoscope with diluted tincture of iodine (diluted to 1 or 2 per cent) or a 2 per cent solution of copper sulphate. If there is prostatitis, or vesiculitis, the prostate or the vesicles must be massaged (but gently, gently, sir!) twice a week, and hot rectal tubes inserted once or twice a day (see below). If there is a stricture, it must be dilated or in extreme cases cut.

If the patient's impotence is due to pollutions or spermatorrhea, these must be treated vigorously. As the treatment of pollutions and spermatorrhea has been discussed fully, we will not allude to them here, but will refer

the reader to the chapter dealing with the treatment of those disorders.

Where we find the cause to be sexual overindulgence or coitus interruptus, the causes must of course be removed, discontinued. But it is a mistake to think that the mere removal of the cause will cure all patients. Undoubtedly, it may in some instances; it will improve them in others. But as a rule some damage has been done, and besides removal of the cause, the patient will need some local and general treatment, which will be discussed presently.

And so with all other causes. While it is unfortunately not true that *oblata causa tollitur effectus,* for the cause has succeeded in leaving some very distinct marks, still we certainly cannot hope to accomplish much as long as the cause lasts. For instance, if a man's impotence is due to some terrible worry, then you may treat him as much as you want, you will not cure him of his impotence as long as the worry continues. You may improve his general health, you may even cause some improvement in his libido, but the potentia will be but slightly affected. Where the impotence is due to excessive intellectual labor, you have to stop that. I know an intellectual worker who is very weak sexually in the winter. In the summer, when he goes to the Thousand Islands, doing nothing but loafing, fishing and gardening, he is all right.

The so-called organic causes of impotence, deformities and malformations of the penis, are of little interest, because they are rare per se, and as causes of impotence they are still rarer. And besides the method of treatment is self-evident. Epispadias and hypospadias are to be corrected surgically, varicocele if really annoying and a prob-

able contributory cause to the impotence should be removed, a hydrocele is to be tapped, a large scrotal hernia is to be operated on, etc.

The Usual Case of Impotence. But let us now consider sexual impotence proper, that is sexual impotence without underlying gross pathological lesions, without even a clearly ascertainable cause, or with a probable cause which has long since ceased to exist, or one which is apparently congenital. Cases of this type of impotence constitute a large percentage of the practice of the specialist in sexual disorders. A man comes in. His age is anywhere between 25 and 55; he may be younger or older but we will take the average case. He may or may not be married. Yes, he has masturbated somewhat, but moderately, when a boy, but he had given up the habit long ago. He has indulged in intercourse, moderately. He may or may not have had a gonorrhea. No, he doesn't work hard. No, he can't say he is worrying. Everybody has some business troubles, some annoyances, but "nothing special." Appetite fair, sleeps well, attends to his job or his business as usual. In fact he says he feels all right in every way. But for the last few months, or for the last year or two, his sexual power has been getting weaker. The erections do not come when he wants them to, or they come at the slightest provocation but are feeble, subside quickly, and the ejaculation takes place very quickly, sometimes *ante portas*. That's the whole kernel of the matter, and that is the complaint of ninety per cent of our impotent patients; *weak or deficient erection and ejaculatio praecox*. The libido may or may not be impaired, and the *voluptas* of

the orgasm may or may not be diminished, though in the majority of cases it is.

How shall we treat such patients? That is what we are going to consider now.

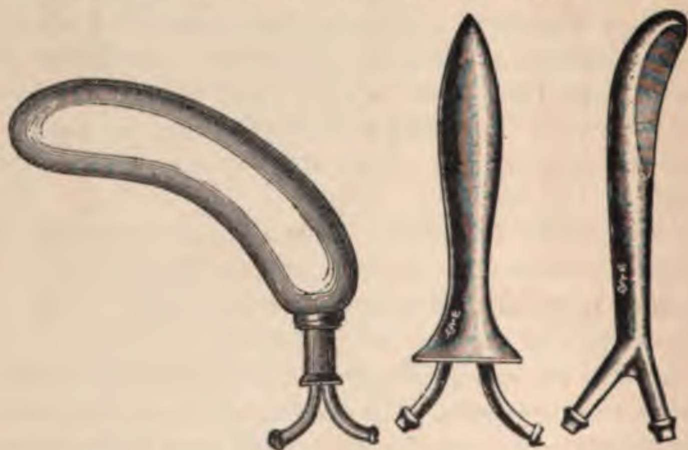
Sexual Rest. First of all I order a complete sexual rest. As to the length of that rest, that depends upon the age of the patient. In young people, I do not hesitate to make it two, three or in severe cases even six months. It cannot hurt them, and the rest alone sometimes effects the cure; if not completely, the greater part of it. In people after 45, afflicted with sexual weakness, it is rather dangerous to prescribe long periods of absolute continence, for we find that in some cases the weakening instinct goes to sleep altogether. In cases after 45 or 50 I simply order moderate and regular intercourse — once in two or three weeks (please bear in mind that I am speaking here of the "pure" impotent without patches in his urethra, — without prostatitis, etc., without symptoms of neurasthenia).

Cold Water Injections. Then I inject cold sterilized water in the urethra (a half per cent boric solution or normal saline solution is sometimes preferable). But the water must be cold, and of this you may inject three or four 100 cc. syringefuls, telling the patient to urinate after each syringeful. This has a very nice tonic effect. It stimulates the posterior urethra and seems to strengthen the openings of the ejaculatory ducts. In mild cases a few of these treatments will alone effect a remarkable improvement. But in the majority of cases we need of course other means.

The Psychrophore. The psychrophore or cold water

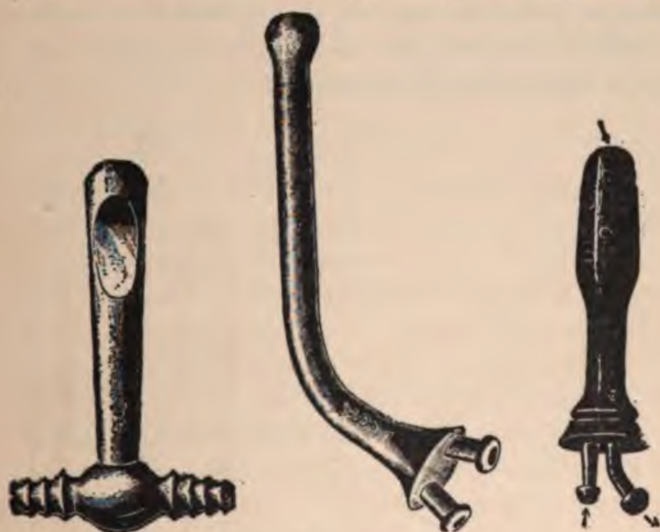
sound is a very useful instrument. This is a hollow double current metal sound (see illustration) which is introduced

into the urethra and bladder. One end is connected with a rubber tube leading to a large glass reservoir (or fountain syringe) filled with cold water; to the other end a rubber tube is attached, which leads into a waste pail. At first the water may be of room temperature, just as it comes



from the hydrant; but after a few minutes, it is best to lower the temperature of the water by putting some ice into the reservoir. The sittings at first last 4–5 minutes, but gradually they are increased to 15–20 minutes. The tonic and beneficial effect of the psychrophore is beyond

question. But in conjunction with the urethral psychrophore, it is always advisable to use a rectal or prostatic psychrophore. Of these we have a large variety, as can be seen by the illustrations. The rectal psychrophore may be used synchronously with the urethral, or in alternate treatments. It is necessary to mention that in some cases we are able to use the rectal psychrophore only, because



some patients are exceedingly sensitive to any urethral instrumentation. No matter how careful, gentle and aseptic you may be, they will develop a chill, the urine may get turbid, and they may feel generally worse. With the rectal psychrophore no such untoward effects take place.

In some cases, a very few however, the psychrophore alone, the mere contact of the cold metal with the urethral mucous membrane or the prostate, does not have the de-

sired effect. And in such cases irrigating the urethra or rectum with cold water sometimes acts much more quickly and surely. For this purpose we have a large number of urethral and rectal irrigators (see illustrations).

Sometimes we wish to use hot water instead of cold; we find occasionally that alternating heat and cold has a very happy effect. For this purpose, we need only fill the reservoir with hot water, or we can have two reservoirs, one filled with cold, the other with hot water, and we change the attachments accordingly.

CHAPTER TWENTY-FIVE

MEDICINAL TREATMENT

As in the treatment of most chronic diseases, drugs play but a secondary rôle in the treatment of sexual impotence. If I had the choice between local and hydrotherapeutic treatments on the one hand and drugs on the other, I would unhesitatingly select the former. But I should not like to be deprived of the aid afforded by the latter. Impotence and sexual neurasthenia are such complex disorders, that we have no right to discard any help, which any agency, material or immaterial, offers us. And drugs form a very valuable adjunct in the treatment of sexual disorders. If they are apt to be neglected, it is not so much the fault of the drugs, as of their users, who are not familiar with the proper dosage, indications and contraindications. It is unfortunately only too true that our urologists and sexologists know next to nothing about pharmacology and medicinal therapeutics. And this is a great pity — for the patients' sake, especially.

Strychnine. Strychnine is one of the few drugs from which we can expect positive results. But it is not to be given in a routine way. Its effect must be watched; otherwise it may do harm and not good. In fact as we have seen above in discussing the etiology, it may even very much aggravate the condition; it may convert impotence of a very mild degree into one of a severe type.

I was the first, I believe, to call attention to the po-

tentially injurious effect of strychnine in sexual weakness. Very soon after my paper made its appearance, I began to receive letters from various parts of the country, corroborating my statements. Some physicians wrote that they had noticed that effect upon themselves; others wrote that they noticed it on several of their patients. But of course they hesitated to come out in print with their observations for fear they would be laughed at. And again they thought it might be a pure coincidence. To repeat then, strychnine must be administered with watchful caution. For instance, if the patient feels irritable after it, if his spine and legs feel hot, or if the slight pain in the back is aggravated, then it is a signal to discard it.

But if we bear in mind the necessity of watching the patient, we can get excellent results from strychnine. Its effect in increasing the erections, their strength and duration, is in some cases extremely gratifying. I usually administer it per os in doses 1/30 or 1/20 grain (according to the weight of the patient) 3 times a day. No results need be expected from smaller doses than 1/30 grain. Sometimes when it is necessary to make at once an impression on the system, I give it hypodermically, and do not hesitate to inject as high as 1/12 grain.

As to the discussion which salt of strychnine is the best to use, the sulphate, nitrate, phosphate, valerate, etc. (in some European countries the nitrate is the favorite), I do not take any stock in it: it is the strychnine, the alkaloidal base, that does the work, and not the acid radical.

I often alternate strychnine with the second alkaloid from nux vomica, namely, brucine. Brucine is mild in its action and may be given in doses of 1/6 to 1/4 grain 3

times daily. Give the strychnine for a week or ten days, then stop it altogether for 3–4 days, and give the brucine for a week, then commence again with the strychnine. Very often the compound syrup of hypophosphites acts more quickly and more beneficially than strychnine alone.

Alcohol. Next to strychnine we have to mention alcohol. A glass or two of beer, a glass of wine or champagne, taken late in the evening when intercourse is intended, has sometimes a very happy effect. (But bear in mind again, that I am speaking here of impotents who are not neurasthenics.)

Cantharidin. Cantharidin, administered carefully in very small doses (1/600 gr.) and gradually increased according to the tolerance of the patient (strangury must never take place; if it does, you have overstepped the limit), is very useful. That it has a selective action on certain portions of the genito-urinary canal nobody will doubt, who has taken a good dose of it, or who has administered it without due caution to others. And its effect in initiating erections, in maintaining them, in increasing the libido will not be doubted by anybody who has had considerable experience with this curious and powerful active principle of the Spanish fly. Of course in administering the crude and variable cantharides or even the tincture we often court failure — or unexpectedly severe action.

Other Drugs. Atropine and ergotin as well as cotarnine phthalate or hydrochloride (styptol and stypticin) are useful symptomatically, and I often prescribe them. The glycerophosphates I believe are useful. But as I generally prescribe them in combination with strychnine

it is hard to determine the exact share of credit due to each. The same is true of lecithin. About phosphorus (in the elementary state) I will say this: Some consider it valuable; maybe it is, maybe it is not. All I can say is that I have never been able to convince myself of its value. And I prescribed it in many cases. I will say the same of yohimbin and muiracithin, and the extract of muira puama. Quinine is often prescribed by Italian physicians, but this is undoubtedly due to the fact that so many people in Italy are malarially tainted. People who never had malaria should not be dosed with quinine. Cocaine is distinctly injurious. While it may at first produce a little exhilaration and increased libido, it will soon make bad matters worse. At any rate only a lunatic will play with such a hundred-edged sword as cocaine. A good dose of tinctura capsici or tinctura zingiberis is often very effective. As to damiana, the drug which was lauded as *the* drug for sexual impotence, the drug which has brought thousands of dollars into the coffers of deceived or unscrupulous manufacturers, I will say that it is *utterly* worthless. It is no more an aphrodisiac or tonic than licorice is. How it ever gained the reputation as an aphrodisiac, is one of those mysteries, which will have to go unexplained. Unless there was a well devised plot to fleece the gullible profession and the still more gullible public, I cannot understand its one time vogue.

Organotherapeutic Preparations. As to the organotherapeutic preparations, I wish they had justified the expectations which were put on them. Alas, they have not! And still, this is probably the path which we will have to follow in our search for a genuine sexual stimu-

lant-tonic. There is no reason why we should not be able to obtain an efficient prostato-testicular extract to be used hypodermically or intramuscularly. Of the various preparations on the market, I can only say that I have given them a trial, but have been unable to arrive at any definite conclusion. Sometimes there *seemed* to be a good result, but just as often if not oftener there was complete failure.

Poehl's expensive spermin preparations, both for hypodermic injections and for internal administration, I have used in several cases, but have not been able to see the slightest result from them. As to Brown-Sequard's elixir of life, it is unnecessary to state that it has failed to accomplish what its enthusiastic originator thought it would, might or did accomplish.

However, I have given small doses of suprarenal, thyroid and pituitary extracts with what seemed to me undoubted benefit. The thyroid seemed to influence the general metabolism very favorably, while the tonic effect of the adrenal was clearly seen. Of course, these opotherapeutic substances will be prescribed with care and only when the physician can see the patient frequently. Under no circumstances are the prescriptions calling for them to be repeated without the physician's distinct order.

Hydrotherapeutics. Hydrotherapy plays an important rôle in the treatment of sexual impotence, only second to the rôle it plays in neurasthenia. The various baths are of great and undoubted value. I am not a believer in the indiscriminate use of cold water, in any condition. In certain neurotic conditions, in certain stages of pollutions, and even in "perfectly" normal people cold water has sometimes a deleterious effect. So even cold water we

cannot order indiscriminately. Some can stand cold ablutions, douches, etc., only, if they have their feet in hot water. With the restrictions indicated above, cold water in various forms is extremely beneficial. The best forms to be recommended are cold ablutions, the sponge bath, the shower or douche and sitz bath. The latter is particularly useful. The sponge bath may be taken, if the patient is very sensitive, with the feet in hot water. He dips the sponge in cold water, rubs each part of the body briskly, and then dries himself with a rough towel until the skin is dry and glowing. If the regular full tub bath is used, the patient is to jump in, stay but a few seconds, come right out and dry himself. What we want is just the shock; we do not want to use the full bath as an antipyretic. A very beneficial form of bathing is river, lake or sea bathing, particularly the last. Unfortunately these forms of water can only be used in certain seasons of the year and in certain localities.

I have also used carbon dioxide and oxygen baths (Perogen) with good results.

Vapor baths and Turkish baths are generally useless, if not injurious. They are not permissible even in obese patients, because I do not believe in vapor and hot air baths as a means of reduction of superfluous flesh. The pound of water that the patient loses while in the bath, he makes up very soon after he leaves it, by drinking excessively. An occasional Turkish bath in autotoxemic conditions and for the sake of cleanliness may be permitted.

Another form of bath which is very beneficial and which contains no water at all is the air bath. I have been recommending it for many years. Almost from the cradle

to the grave the human body does not come in full, free, immediate contact with the outside air. Which is a pity. I find it very beneficial for impotent patients and for others as well, to walk about perfectly nude in their room for at least 10 or 15 minutes daily. If they are sensitive to cold, they may perform some exercise while taking the air bath. In warm weather some people I know spend hours attending to their work in a perfectly nude condition, and claim to be very much benefited by it. Sunbaths I consider injurious.

The Diet. The diet should be generous and liberal. The patient should eat plenty of eggs, oysters, raw and fried, meat and fish. I often make my patients eat two to six raw eggs a day, two or three the first thing in the morning, before breakfast, the rest during the day. It is best to drink the egg directly from the shell. Make a hole at the top, put in a pinch of salt and sip it. Caviar is also reputed to be beneficial. Spices and condiments are not only permissible, but desirable. Saffron, pepper, mustard, cardamon, cinnamon, nutmeg, ginger have an undoubted effect in stimulating the libido and the erection center; and where lack of libido and weak erections or weak erections with retarded ejaculations are the only complaint, they may and should be used liberally. Unfortunately, these spices have also the effect of stimulating the ejaculation center, and where ejaculatio praecox is a prominent or chief symptom, they must be eschewed or used only with great circumspection. As to alcoholics, I spoke of them when considering drugs, for alcohol should be considered as a drug and not as a beverage. There is one spice or condiment of which I hesitate to speak, be-

cause it is held in such contempt and disdain in this country. I refer to garlic. There can, however, be no question as to its *pronounced aphrodisiac effect.* In fact it stands at the very head of the list. But many of our Anglo-Saxons would perhaps prefer their impotence to the alternative of having to eat garlic. The nations, however, who have no such loathing against the bulb of *allium sativum,* the Italians and Jews for instance, often make use of garlic as an aphrodisiac; some do it without deliberation, instinctively, so to say. I have tried in several instances to administer, instead of the garlic the distilled oil or the artificial oil of garlic, which is chemically allyl sulphide ($C_6H_{10}S$). I administered it in capsules, but the effect was not quite the same. Onions (raw) have also a stimulating aphrodisiac effect, but less pronounced than garlic.

It should not be necessary to say (and still I say it because I have found out that in lecturing and writing misunderstandings are only too frequent, and it is better to emphasize a little too much than not enough), that this rich and liberal diet is not to be recommended to obese people or to people who are beginning to travel that way. It is not wise to stimulate their appetite too much, for too much food of whatever kind means additional tissue.

CHAPTER TWENTY-SIX

EXTERNAL APPLICATIONS

I often prescribe external applications to the penis. A stimulating ointment appears to be beneficial. The following formula has been prescribed by me for many years:

℞ Camphorae ....gr. x
Oleoresinae capsici............gr. ii
Olei sinapis ....gtt. ii
Petrolati ....℥ ii

A very small quantity (about the size of half a pea) is rubbed in around the root of the penis at night. The sensation of warmth lasts for a long time, and in cases of frigidity or diminished libido exerts a beneficial effect.

The penis is to be washed off in the morning with soap and water, and some talcum applied, so as to avoid irritation.

I was told by two or three patients that a druggist was selling an ointment which was very good for impotence. As I am not in the habit of sneering at anything without investigation, and as I always like to consider suggestions no matter from what source they may come, I investigated the matter and found that it was an ointment made from crushed and strained garlic and lard. A small quantity of this was rubbed into the penis and on the back and while the result is of course temporary, it is undoubtedly beneficial.

There are various mechanical appliances which are used

on the genitals with apparent benefit. One consists of a vacuum pump and cup; both the penis and scrotum are enclosed in the cup and a partial vacuum is produced, which is maintained for 10 minutes to half an hour. I cannot exactly see the rationale of the action of this passive hyperemia, but Zabludowsky of Berlin claimed good results with it, and my patients say they are benefited by it and ask for it. Another little appliance is for the penis alone; this I have not found so useful, though where the organ is very shrunken its use is not irrational.

No sufferers are so afflicted with credulity and gullibility as are the victims of sexual impotence and the market is flooded with various appliances which are guaranteed to be sure cures. It goes without saying, that most of them are worthless frauds. One of the worst of these frauds is a certain little appliance which the manufacturers have had the impudence to call Bier's Erectruss, thus giving the impression that the thing has Prof. Bier's approval, or is his invention. I have met intelligent physicians who really thought that Bier recommended that piece of iron wire in sexual impotence. It costs the manufacturer about 5 cents apiece, and they have the hardihood to sell it for $10.00 list, or to physicians for $5. And there are medical journals, which are advertising this fraud. But I am sure that most of them are doing it through ignorance. Did they know the worthlessness of the thing, and the questionable methods of introducing it, they would throw it out of their pages instantly.

The "back" also needs treatment. For this we use one of several applications. My two favorite ones are:

℞ Chloroformi ....℥ i
Tr. Belladonnæ ....ʒ vi
Tr. Capsici ....ʒ ii

Sig. Paint spine with camel's hair brush.

℞ Camphorae ....ʒ ss
Chloralis ....ʒ ss
Pulv. Capsici................ʒ i
Ol. Sinapis.................gtt. x
Petrolati ....℥ i

Sig. Apply externally to back with vigorous friction.

Painting the back with pure chloroform until there is a sensation of lively burning is also good.

Massage of the back, vibration and concussion of the spine are decidedly useful.

Touching the skin over the exits of the spinal nerves with a red hot wire or with the electric cautery may seem a cruel and antiquated method of treatment. So it is. Nevertheless I make use of it occasionally in certain classes of sexual patients, where it is necessary to make an impression. The stimulating effect of acupuncture and electropuncture is undeniable. Dry cupping of the back is also a very beneficial and grateful procedure; unfortunately the old-fashioned cupping is becoming a lost art.

Electricity. What I have to say about electricity will probably be surprising to many who have come to regard this wonderful and mysterious force as a panacea in a long list of diseases, particularly of a neurotic character. Far be it from me to say that electricity exercises no beneficial effect in impotence. But I do mean to say that the benefit derived from electricity is less than from almost

any other method. And it is hardly worth the outlay and the trouble. And I am not sure that even the little benefit derived therefrom is not largely of a suggestive character. And this is how I explain why electricity *used to be much more effective in former years than it is now.* Two or three decades ago it was something new, mysterious. The patients were duly impressed and the suggestion which is always operative in every new method of treatment, particularly if it is complicated and elaborate, did the work. Now, every patient knows electricity. They see it everywhere. And the suggestive element is therefore eliminated. And the results are therefore poorer. It is not rare to have patients tell you: "But I hope you won't treat me with electricity. I have had too much of it. It didn't do me any good."

And so my opinion of electricity is not a very high one, though I do not deny its occasional usefulness. But I do not wish to be dogmatic. It is possible that the results reported by others have really been achieved in their hands; maybe they are more competent — or more fortunate.

Exercise is naturally advisable on general principles, to improve the general health. But it is not a panacea for impotence, any more than the constantly lauded fresh air is. I might as well remark here as elsewhere that hygienic living, while advisable for every human being, will not alone restore sexual power to one who lost it or never possessed it. It is simply one of the secondary adjuvants in the treatment, and not even a very important one. As to walking, this is decidedly a double-edged sword. In patients suffering with premature ejaculations (also pollu-

tions and spermatorrhea) I have seen it more than once aggravate the condition, so that I advise my patients to take but short and frequent instead of long and fatiguing walks. And the walks should be taken in the morning and afternoon rather than in the evening.

Apparatus. A word about the various apparatus, which are used in form of "splints" to encase the penis, and make its introduction possible, where it is otherwise impossible, on account of lack of erections. Of course this is no treatment, no more than a crutch is a cure for a lame leg. But the comparison is in favor of the crutch; because while it is of use while a broken leg is healing, a penile splint does not strengthen the sexual power. On the contrary, it may even exhaust it more completely. Nor is it easy to understand, how any normal and self-respecting man can enjoy intercourse with the membrum virile encased in a splint. But in cases where one or both of the parents are anxious for an heir (or heiress) and impregnation is impossible on account of absence of erections, or of ejaculation taking place *ante intromissionem* the use of a penile splint is permissible.

As to *suspension* — suspending patients from a Sayre straight-jacket, I take no stock in it. The few reported cases of temporary and partial improvement can be quite justifiably ascribed to the element of suggestion.

I have not spoken of psychic treatment, because in the variety of impotence which we are discussing now, psychic treatment plays but an insignificant rôle.

It will be referred to in the discussion of the treatment of sexual neurasthenia.

There is one important point that we have to bear in

mind. After we have cured a patient and have restored him to his former power, it does not mean that he will in every instance stay cured, if he does not take judicious care of himself. Very often we must enjoin upon a patient regularity in the exercise of his sexual function. If he should abstain for some months, and then indulge, perhaps too frequently, then again abstain, he may get back again into his former condition. He needs regularity and he must of course avoid all those causes which were responsible for his impotence. Disregard of these commonsense points is responsible for many relapses.

In a certain number of cases, even under the most favorable conditions, the improvement obtained by the treatment will be only temporary, lasting from a few months to a year or two. But this is not such a calamity. The patient merely repeats his treatment every once in a while. I have a number of patients, ranging in age between forty and seventy, who come around regularly about once a year for a few treatments. They claim that their potency is always better after the treatments, but the effect begins to wear off in six or eight months. After a few local treatments combined with general tonics and hygienic advice they are again all right. And I am sure that by these wise and prophylactic procedures these patients have had their sexual life prolonged for many years. It is certainly easier to cure a case of impotence taken in hand at its first manifestations than one fully developed.

CHAPTER TWENTY-SEVEN

PSYCHIC IMPOTENCE

I shall not write much about psychic impotence, because, contrary to the belief and writings of some confrères, psychic impotence does not play a very important rôle in the various kinds of sexual impotence. A man quite normal in all respects does not all at once imagine that he is unable to consummate sexual intercourse. I probably see more cases of sexual impotence than any other physician in America, and I will say that imagination plays a very insignificant rôle in the etiology of impotence. Many cases which had been diagnosed by other physicians as psychic were on careful examination found to have an inflamed posterior urethra, or colliculus, or an atonic prostate; or there were points in their history — masturbation, excessive venery or complete continence — which fully accounted for their impotence, for their lack of libido, for inability to get an erection or for their premature ejaculation. And I am sure that if all patients were carefully examined and their histories minutely inquired into the number of cases of purely psychic impotence would be getting gradually smaller.

I do not at all wish to be understood as denying the existence of psychic impotence, but I do asert that its importance has been and still is greatly exaggerated, and from analyzing cases reported by the older writers and as a result of experience with patients sent to me by other

physicians, I am sure that psychic impotence has often been diagnosed incorrectly. And then the term is used too indiscriminately. If a man is unable to have a desire or get an erection with a certain woman, who is distasteful to him, or who has dirty underwear on, or who has a bad odor from her mouth, then this is not psychic impotence: it is simply lack of a proper stimulus. And if a man who is burning with desire for a certain woman gets an immediate ejaculation with that woman, while he is normal with other women for whom he does not care so much, then this is not psychic impotence: it is simply over-stimulation of the ejaculatory center. As to the cases which have been reported of men who could perform the act only under peculiar conditions, as for instance with women dressed in riding habits, or in full evening dress, or in a Turkish costume, or only at certain hours of the day, or only in rooms furnished in a peculiar manner, or in certain grotesque positions, or only when maltreating women or being maltreated by them, they belong in the domain of mental abnormalities and perversions, and *medical* treatment is of little avail in such cases. Besides they are very rare and even the busiest specialist in sexual disorders sees them but at rare intervals. That there are psychic elements, such as fear of detection, unclean room, necessity for hurrying, fear of venereal infection, fear of impregnating the woman, lack of responsiveness or unconcealed aversion on the part of the woman, which will temporarily render a man impotent, so that he can get up no erection, is fully admitted of course. But this is not psychic impotence. These are temporary affairs, and the causes being removed, the impotence disappears.

I apply the term psychic impotence only to a restricted

class. A man perfectly healthy sexually and not neurasthenic gets it into his head that he will not be able to accomplish intercourse. It may happen to a man who was absolutely continent before marriage,* or he may have abstained for two or three years, or he may have read in some quack or semi-scientific book that all those who at one time masturbated become impotent; in short, for one reason or another he gets that idea fixed into his mind, and though the woman may be everything his heart or fancy desires, and though his libido may be intense, he fails to get an erection. At other times when alone, when waking in the morning, his erections may be strong and of long duration. Such are cases of true psychic impotence. On examination no pathologic lesions are found and the miraculous results of a placebo show the true nature of the disorder.

The Treatment of Psychic Impotence. No rules can be laid down for the treatment of psychic impotence. A physician with good judgment and tact will accomplish everything, a physician without these qualities will accomplish nothing. We must size up our patient, ponder carefully over his history and act accordingly. But as a rule it is not well to pooh-pooh the patient's notions, and tell him that there is nothing the matter with him and that he will be all right. A generous supper with some wine and liqueurs often proves the best remedy. It is good to have a confidential talk with the wife, and if she is not a prude or a cold-blooded animal, her coöperation will prove valu-

* In some men who have been completely abstinent until marriage, the sex instinct may become very much repressed. They develop a condition analogous to what we call Frigidity in the female, and to this condition we may apply the term Psychic Impotence.

able. Suggestion is a necessary adjunct, and it is best to give him some treatment — electric or vibratory — and prescribe a placebo which he is instructed to take with religious regularity.

It is a good idea to order the patient to abstain absolutely from all attempts at intercourse for a month or two, taking in the meantime some indifferent sort of granules. As a rule almost without exceptions, where the impotence is really psychic, the physician's injunction is broken long before the appointed time.

Thus, for instance, a recently married patient comes to you and complains that he is entirely impotent; after you have listened to his history, have examined his genitals by inspection, palpation, etc., have examined the prostate, have examined the urethra, colliculus seminalis, etc., by the urethroscope and have made up your mind that you have before you a case of psychic impotence, you prescribe 200 or 300 granules of a very small dose of some mild tonic; say 1-60 gr. of arbutin or of brucine or 1-6000 grain of cantharidin; you order him to take one granule 3 times a day after meals and abstain *absolutely* from any attempt at intercourse until *all* the granules have been taken, that is for two or three months. You will find in a vast majority of cases that before half of the granules had been taken, the patient disobeyed the order and consummated the act to the perfect satisfaction of both parties. He will tell you, perhaps somewhat sheepishly, that he had a strong desire and couldn't help it, or that the wife demanded it. But I must add that this scheme works well only in the case of married men, where the opportunity for gratifying a

suddenly awakened desire is always at hand. In the case of non-married people, the lack of opportunity *at the proper moment* often frustrates our efforts. And such an opportunity must be created.

CHAPTER TWENTY-EIGHT

REPORT OF CASES

Case 1. Age 22. A typical case. Suffered with bed-wetting until the age of ten. Masturbated moderately and intermittently from the age of thirteen to about sixteen. At about fifteen began to suffer with night emissions; first every two or three weeks, then every week, then twice a week and even oftener. Felt tired and languid in the morning, i.e., after an emission. Some six months previously applied to a physician, who gave him bromides and advised him to attempt intercourse. He did, but had an immediate ejaculation, without any erection. Three or four more attempts proved just as unsuccessful. In the meantime the pollutions kept up with the same frequency. When he came to me he was thin, pale, emaciated, with an awkward gait, and a restless wandering look. His memory was weak, and he was painfully lacking in power of concentration. He had passed the junior examination in the New York College of Pharmacy, but in the senior year he found it impossible to prepare the lessons, and left college, until his health should improve. He had a woe-begone expression and his outlook on his future was decidedly pessimistic. I assured him in the most positive terms that I could cure him unquestionably, provided he would put himself entirely in my hands, and without reasoning or questioning do whatever I ordered. He was only too ready to accept the terms. Such weak

characters need a superior will and they at once feel better as soon as they know there is a stronger personality to guide them and to order their life. Unrestrained, unfettered liberty is not everybody's ideal. I examined him, and though I had given him no treatment that morning, he left the office in a much better, more hopeful mood than when he came. The first two months the treatment was general — I told him he should forget that he had any sexual organs — and consisted in iron, nux vomica, syrup of hypophosphites, glycerophosphates, warm and cold baths, rectal enemata of cold water, plenty of meat, raw eggs in the morning, etc. He gained about ten pounds, his anemia disappeared and he looked and felt brighter. I then proceeded with local treatment. The posterior urethra was quite sensitive and so was the prostate. The urethra was treated with steel sounds, Kollmann's dilators, urethral psychrophores, instillations of hydrastine, and of silver nitrate; the prostate was very gently massaged twice a week, followed once a week by faradization and once a week by hot and cold rectal applications. He was also given rectal suppositories consisting of ichthyol, antipyrin and atropine, to be used each night on going to bed.

After six months' treatment he attempted intercourse, which, however, was not fully satisfactory. The erection was strong, but subsided quickly and was followed by a premature ejaculation. Treatment was continued off and on for another year; it was interrupted for three months during my annual vacation in Europe. At the end of this period the man was perfectly well. He was an entirely different man both physically and mentally. Intercourse was perfect both as far as erection, duration and

sensation were concerned. He married six months later and is living a happy married life.

This case is not in any way unique. On the contrary it is a common, every day case, and well illustrates what can be done by persistent judicious treatment. Had he fallen into improper hands, or had he married before a complete cure had been effected, he would have had a life of misery to look forward to, misery for himself and for his wife; and knowing his sensitive character and his tendency to pessimism and melancholia as well as I do, I feel quite certain that sooner or later he would have terminated that life of misery by his own hand. It is the good luck of the patient that he was well-to-do and could afford prolonged and expert treatment. But what are the poor — workingmen, clerks, small business men, etc.— to do, when they are afflicted with impotence? The hospitals will not receive them, and the treatment dealt out to such cases in the dispensaries is worse than useless.

Case 2. Twenty-eight years old. Masturbated from the age of thirteen or fourteen; occasional intercourse from the age of twenty-four. Weak sexuality in general. Lately began to notice diminishing potency: weak erections, premature ejaculation. Never had venereal disease. Examination discloses very narrow prepuce; patient states that he had not retracted it for years. Retraction, which was accomplished with considerable difficulty, discloses an accumulation of smegma, of a foul, sickening odor, and several preputial calculi; several small ulcerations on the superior surface of the glans. Thorough cleansing with soap and warm water, then with peroxide; then touching the ulcerated spots with a 10 per cent solution of silver

nitrate; ordered washing with peroxide of hydrogen three times a day, then dusting with an antiseptic powder. In a week the balanoposthitis completely healed. Ordered abstinence from intercourse for two months. In the meantime warm sitz-baths at night, and cold baths in the morning. No internal treatment of any kind. At the end of that period tried intercourse with perfectly satisfactory results — in fact more satisfactory from every point of view than ever before in his life. Has given up masturbation entirely, and lives a normal sexual life.

Case 3. Age thirty-five. Single. Lived a normal sexual life from the age of 22, having intercourse regularly once a week to once in four weeks. Never had any venereal disease. For the last year notices premature ejaculation and diminishing libido. Feels well otherwise. Leads a sedentary life. Investigation discloses the fact that he has always suffered somewhat from constipation, but that the condition has become considerably worse during the past year, and he has also begun to develop hemorrhoids. The prostate not enlarged, but somewhat painful to the touch, and slight pressure causes prostatic secretion to appear at the meatus. I consider the condition due to constipation and prostatic atony. Treatment: an enema of warm water with soapsuds at night, followed by an injection of 8 ounces of cold normal saline solution, retained in the rectum for ten minutes. In the morning a mild saline laxative, alternated with rhamnus purshiana, and aloin, strychnine and belladonna pills. Massage of the prostate once a week, for four weeks. No treatment of the urethra. After six weeks' treatment, complete recovery.

Case 4. Age thirty-two. Married one year. All-

around athlete. Masturbated from the age of 15 to 18, when, being informed of the injuriousness of the habit, he gave it up definitely. Intercourse at the age of 20, and two years later contracted a gonorrhea, which lasted eight months, and was accompanied by prostatitis. Became engaged at the age of 28, from which time until his marriage — a period of three years — abstained from intercourse. Immediately after marriage found that the performance of the act was unsatisfactory, but as his bride did not seem to be dissatisfied, he delayed attending to himself. Lately, however, he has noticed a distinct aversion on her part to his approaches, and has also perceived that intercourse left her irritable and complaining of backache, headache, etc. His complaint is lack of libido, premature ejaculation, sometimes even before intromission, a scalding feeling during the emission, and a sense of lassitude after the act. But while the purely physical desire for the act was diminished, the *mental* desire remained as strong as ever; if anything it was increased. Findings on examination: posterior urethra exquisitely painful, prostate somewhat enlarged, boggy and painful, abundant secretion readily expressed. Testicles and epididymis not enlarged, but tender to the touch. No gonococci, no shreds in the urine. Treatment consisted first of all in forbidding any attempt at sexual intercourse "until further notice." I gave him to understand that this was a *conditio sine qua non,* and told him that I would not take his case unless this condition was absolutely complied with. He agreed.

I then gave him one milligram (1-64 grain) of atropine sulphate three times a day. This relieves congestion of the posterior urethra and the neck of the bladder very

markedly, a fact unfortunately not well-known to the medical profession. A week later I began cautiously the passing of steel sounds; started with 18 French, increasing the size gradually, until at the end of three months I was able to pass 29 French easily. The sounds were passed twice a week; besides, he had his prostate massaged and faradized once a week; once a week he had 30 minims of a 1–1000 silver nitrate solution instilled into the posterior urethra and once a week the solution of strychnine and hydrastine. At the end of three months' treatment, he was advised to attempt intercourse. There was a very decided improvement in every respect, but it was not perfect. The ejaculation was still somewhat premature. I told him he would have to continue practically the same treatment for three months more, during which time he must abstain. He obeyed for two months; at the end of that time he broke the injunction and had relations with his wife, which were highly satisfactory to both parties. He continued treatment for another month, and he has been in perfect health since.

Case 5. Age 74. As typical a human wreck as one would care to see. Wrinkled, jaundiced, with a dragging gait, false teeth, dyed hair and an extremely offensive breath, but well dressed and dandified, he gave at once the unmistakable impression of an old incorrigible roué. He wanted me to give him a thorough examination and see what I could do for him. I found him suffering both with chronic gonorrhea and tertiary syphilis. The urine contained pus cells and numerous shreds; the prostate was enlarged and very painful; and evidences of tertiary syphilis were seen everywhere. When I explained to him

his condition, and told him that he would need long and careful treatment before he could hope to be in good shape, I discovered to my disgust that he was not interested either in his gonorrhea or in his syphilis. All he cared about was to be "fixed up" so that his sexual power should be normal again. He indulged all his life very frequently, but during the last year or so he felt his sexual powers waning. I asked him if he did not think it was about time to leave his sexual power alone, whether he was not too old to bother about it, and he felt quite offended. I asked him if he thought it right to indulge in sexual relations when his victims ran the risk of venereal infection. But he was as rotten morally as he was physically. He didn't care. "They" got paid, and they had to take their chances. A doctor is supposed to treat everybody who appeals to him for aid and the author surely does not often assume the rôle of judge, especially of what is called "vice," but in this case he did feel disgusted and I told him plainly that I would not treat him; that if I could restore his sexual power in one treatment, I would not give him that treatment for a thousand dollars, and that I considered it a very excellent thing that he was losing his sexual power, for he would thus perhaps cease to be a menace to many women and, through them, many men. And I even told him that I considered such a man as he much worse morally than any street walker, and that it was not physical, but moral treatment that he needed. And with that we parted.

Case 6. Age twenty-four; married four months. Was perfectly normal until marriage, and perfectly normal the first three months after marriage. During the last month

began to notice that the erections were weak and imperfect, ejaculations irregular; sometimes very quick, at other times prolonged, but in each case the semen was thin and watery. Examination discloses a strong, passionate fellow (Hungarian). Used to indulge frequently (2 to 4 times a week), but fearing infection abstained for 4 months before marriage. From the wedding night indulged excessively 3 to 10 times in the 24 hours, without skipping a day (even during menses). While at first the wife objected to such frequency, after 5 or 6 weeks she became not only a willing partner, but her demands even exceeded the supply. It did not come to this patient's head, that he was indulging in killing excesses, and that these excesses might have something to do with his beginning impotence. I gave him a lecture; then I prescribed for his wife 60 grains of the combined bromides pro die, and told him that he must abstain absolutely for a month, and after that indulge not oftener than once a week; later on he might permit himself twice a week. I also gave him a placebo — 1 ounce of ac. phosphor. dil.— 5 drops in a little water after meals — which he was to take regularly for a month. At the end of the month he reported restoration to perfectly normal health. In the first attempt the ejaculation was premature, but in the second it was normal, and has remained normal ever since. He leads a moderate sexual life as outlined by me. The wife was inclined to object at first — she thought that once every night would not hurt him, but a confidential talk, in which I explained to her that excess now might mean premature decay later on, put matters right. Married women are not selfish and they make sacrifices much more readily than men do. There

is no question that in sexual matters, man is a selfish brute — generally speaking. Of course there are exceptions on both sides.

Case 7. Age twenty-five, complains of frequent micturition, slight scalding of the urine, erections on the slightest provocation, such as standing up in the subway trains close to a woman, frequent "mucous" discharge from the urethra, almost nightly pollutions, and immediate ejaculation on attempting intercourse. Has never had venereal disease, but investigation discloses the fact that he has been a furious masturbator from the age of seventeen. He masturbated daily, and sometimes several times a day, between 17 and 19, after that about 3 times a week. At the same time he began to have pollutions. He went to a physician, who instead of examining him, gave him some allegedly aphrodisiac pills (containing that humbug damiana, phosphorus and nux vomica) and told him to go with women. Any attempt, as stated above, always resulted in ejaculation *ante intromissionem*. On examining him I found the verumontanum extremely congested and sensitive; it bled at the slightest touch. This was an ideal case for cauterization, and I instilled 3 drops of 50 per cent solution of silver nitrate by the aid of the urethroscope. The pain was excruciating, the strangury following it was severe, for the next 24 hours he passed a few drops of blood at each attempt to urinate, and the erections were acute. But I was not frightened; I was familiar with these symptoms, and I knew that was exactly what was needed in this case. I ordered strontium bromide internally, morphine and atropine suppositories to relieve the strangury, as well as hot sitz baths. In 3 days

all the symptoms following the application were gone, and the patient felt better in every respect. Not only his local symptoms, such as frequency of urination, and the general feeling of irritability in the urethral canal were improved, but his general *morale* had undergone a change for the better. In ten days after the first application I undertook another, but this time I preceded the silver nitrate with a solution of alypin nitrate. The reaction was very slight. In a week I gave him an instillation of silver nitrate — five drops of a 10 per cent solution, and without alypin. The reaction was more intense than after the second treatment, but incomparably milder than after the first. And this, strange as it may seem, completed the treatment. I expected to give him internal treatment, baths, electricity, etc., but I found it was unnecessary in his case. After the third treatment, his pollutions stopped, he had no desire to masturbate, his irritability disappeared, and he felt as he said, using the hackneyed phrase, a new man. I therefore started to wait with any additional treatment. But he did not need any. In about a month after the last treatment he attempted intercourse. He effected intromission readily, though ejaculation was premature. But after two or three more attempts, everything was normal.

Here we have a complete case, where all the sexual troubles — pollutions, irritable and weak erections and premature ejaculations and the resulting general irritability — were due to a purely local cause, and were all removed by exclusively local treatment. Such cases are not very common, but they are more frequent than is generally imagined, and should always be borne in mind.

Case 8. This case is in almost every particular like the

preceding case, except that on account of the extremely narrow meatus I had to do a meatotomy, and that five instillations of silver nitrate were required before a cure was effected. This patient married soon (about three months after the completion of the treatment) and his sexual life has been normal in every way. About a month after marriage, he began to feel a little irritation and burning feeling in the posterior urethra (I ascribed that to excessive intercourse) and the desire to masturbate also seemed to come back, but one instillation of silver nitrate with a few doses of strontium bromide relieved all symptoms, and after that he needed no further treatment.

Case 9. Age 25, strong, ruddy faced, plethoric, emissions about twice a week, intercourse about once in two weeks. Erections strong, but ejaculation very premature, the voluptas of the orgasm, however, is undiminished. Never had any venereal disease. Eats heartily and usually has wine with dinner. Examination shows everything normal. I recognize that this is a case of plethora, excessive elaboration of seminal fluid. I advised him to cut out wine entirely and to reduce his diet somewhat. Medicinally, I prescribed the combined bromides, 30 grains 3 times a day. After 6 weeks' treatment he reports complete improvement in his condition. Emissions reduced to about once in ten days, while intercourse is in every way satisfactory.

Case 10. Age twenty-four. This is a sad case. Youngest of three brothers. They had a vicious maid in their employ for many years. From the history I have no doubt that she must have been a nymphomaniac. She began to masturbate him when he was nine years old. At

first he liked the sensation, but after a year or two he rebelled, but she actually forced him to it, and he was to such an extent under her domination that he was afraid to resist her. Between the ages of 13 and 14 she forced him to have natural intercourse with her, and she compelled him to keep it up for two years, practically every day, without exception; occasionally even twice a day. After that he began to have great difficulty in getting an erection; she commenced to force him to have coitus per os. This was going on once or twice a week for nearly a year. He then became very sick and anemic, a cough developed and tuberculosis was feared. He was sent away to the country for several months. When he returned the maid was gone. (Perhaps because there was no other male in the house.) He believes that the vicious female had done exactly the same thing to his two brothers. One of them died at the age of 28, he did not know exactly of what, the other brother married, but began to live unhappily with his wife right after marriage, and now lives separated from her. He himself has had nothing to do with women since he became free from his tormentor. He never experienced any desire for intercourse. He used to have occasional, though rare, pollutions of a thin, watery fluid, but even they stopped. Recently he met a beautiful young girl, with whom he is in love, and he came to find out if he was fit to get married. I examined him. The penis was as small as that of a boy 6 or 7; small, shrunken, livid; and the testicles were difficult to find. When found, they were felt to be of extremely small size. There was also bilateral varicocele. I told him as gently and as sympathetically as I could that I did not think treatment

would be of any avail in his case. It was a case of complete exhaustion of the sexual center and atrophy of the testicular glands due to terrific abuse of the immature sexual organs in early childhood. I should add that palpation per rectum showed the prostate also to be considerably smaller than normal. He was a nice, pleasant fellow, and I thought it my duty to speak frankly to him, though in as delicate a language as possible. In spite of all I said, he asked me urgently to try and see what I could do for him. His life depended on it. For four months I exhausted every possible means, but as I knew beforehand, all was in vain. I told him it was useless to try any further. And I told that for him to marry an ordinary woman would mean a calamity for both. There are women, however, who are absolutely devoid of any sexual desire and who nevertheless crave for the companionship and the company (the two words are not synonymous) of a good man. If he should happen to find such a woman, he could explain to her his condition, and they could establish a comfortable and perhaps even a happy — in its way — household. He thought at first to begin to study for the priesthood — he is a Catholic and it would not be hard for him to remain true to his vows of celibacy and chastity. He changed his mind, however, and is devoting his time to the study of philosophy, history, economics, etc., and he is relatively satisfied. And he is now keeping company with an estimable young woman who seems to be all mind, and for whom terrestrial things apparently possess no charm.

Case 11. Age 35, married 12 years. The story was told hesitatingly, with many pauses, but briefly it is as

follows: A case of love at first sight. Always passionately attached to his wife, and even now would gladly "sacrifice his life" for her. But nevertheless during the last year began to notice a coolness towards her, and a lack of desire for intercourse; could go for months without the slightest difficulty. Erections slow and rather imperfect; ejaculation, however, not markedly premature, but the pleasure of the act is slight. Had never had intercourse with any woman except his wife, either before or after marriage. Has been having longings for other women, but has strenuously and successfully resisted extra-marital intercourse. I suspected that his trouble was psychic, and not physical. Still I examined him. Found absolutely nothing abnormal. And told him so. Told him I did not think treatment would be of any avail in his case. Still he insisted that I make a trial. After a month's treatment no improvement. And though he requested that I treat him further, I refused. He went to a neurologist who treated him for four months without any improvement. On the contrary, he became worse and the lack of libido became more marked. He came back to me. I thought it was my duty to have a frank honest talk with him. I told him his case was not unique. I explained to him as delicately as I could, that while monogamous marriages were for the best interests of society, still man was by nature polygamous; monogamy was an artificial condition, which while it suited most men perfectly, was very irksome and even unhealthy to some. Especially to those who never had any ante-nuptial relations with other women. I told him that I had many such cases; after one or a few extra-marital relationships, their libido, their power and

their love for their wives returned and they were again in perfectly normal condition. He asked me: Would I advise him to attempt extra-marital relations? I answered him, I would advise him nothing. It was not my province to advise in such cases. My province was to tell the truth as I knew it and to explain matters, from a purely scientific standpoint, without any religious or moral bias. But the conclusions from my explanation my patients must draw themselves. Whether he did draw conclusions and act upon them or not, I do not know.

Is it morally right ever to tell a patient that his impotence is purely psychic, and is due to his dislike for his wife, thus perhaps putting him on the way to extra-marital relations, or is it better to conceal the truth? In other words, should a physician always state the facts to the patient, as he finds them, or should he be controlled in his statements and his advice by his own and his patient's moral and religious opinions? This is a question which will bear considerable discussion.

Case 12. Twenty-five years old. Never had sexual relations. Complains of lack of libido and very frequent pollutions; they occur almost nightly, without any erotic dreams or erections and leave him weak and depressed in the morning. But what annoys him still more, is a feeling of coldness, chilliness, in the lumbar region, around the loins, in the perineum and about the genitals. He always feels cold in the lower part of the body. In the summer it is not so bad, though there is an unpleasant sensation about there, but in the winter no matter how warm he may dress the feeling of chilliness is there. His feet are

very cold at night, and he has to sleep in woolen socks and cover himself very warmly. Examination shows that it is not imagination. The small of the back, the genitals, the upper portions of the thighs actually feel cold to the touch. He has been treated by a number of physicians. One gave him bromides (!!), another one strychnine, a third tried electricity, but he felt not the slightest improvement. The only thing that gave him some comfort was a flannel abdominal bandage. I saw that there was something wrong with the circulation in the lower half of his anatomy and suggested daily massage and hot sitz baths. He could not afford massage, but he could manage to take the baths. I advised him to take one every night, as hot as he could stand it, putting twice or three times a week about two ounces of mustard in the bath. After the bath he was to wash his genitals with cold water, to prevent undue relaxation of the blood vessels. He began to experience the beneficial results of this simple treatment, which was not accompanied by any medicinal measures, after one month. His pollutions became rarer, but began to be accompanied by erotic dreams. My idea was that improving the circulation, increasing the amount of blood, would stimulate the sexual spinal centers and improve the nutrition of the genital organs. I did not consider medicinal or local treatment indicated in his case. I only increased his diet, having him consume generously eggs, oysters, meat, etc. My line of reasoning proved correct. After six months of the baths, which were during the last two months supplemented by home exercise and brisk walks, he began to have strong libidinous desires and his pollutions, while

... ne strongly erotic. An attempt at intercourse ... isfactory. He married six months later, and, ... le not over-vigorous, he is sexually normal, indulging ... e a week with perfect satisfaction to himself and his ... e.

CHAPTER TWENTY-NINE

SEXUAL IMPOTENCE AND ATHLETICS

It is but natural that when we see a ruddy, well-developed, well-nourished and thoroughly healthy-looking individual, we should think of him as healthy in every respect. It is but natural that when we see a six-footer with splendidly developed biceps muscles, who is an all-around athlete, we should think of him as possessed of a powerful sexuality. It is natural that baseball players and prize-fighters and policemen and military men should make a fanciful appeal to the imagination of the feminine half of mankind. But, cruel as it may be to do so, the illusion must be destroyed. A powerful athlete is not necessarily sexually powerful or even sexually normal. Just as a man may be in excellent health and still suffer with weak eyesight or poor hearing, so a strong, well-nourished athlete may be sexually very weak or even absolutely impotent.

I have seen so many athletes who suffered with one form or another of sexual weakness that I began to question if there was not some causal relationship between the physical exercise and the impotence. This may seem a very revolutionary notion — that physical exercise and training should be productive of sexual weakness. But it is not so revolutionary at all — for please remember that more than two thousand years ago the ancient Greeks, who were certainly acute observers, used to

say that all professional athletes were sexually impotent!

This is a subject very well worth investigating and discussing — particularly investigating. And I should be pleased to have physicians who have come across cases of sexual impotence or sexual weakness in athletes give me brief reports of their cases. But an important point is to be borne in mind. We must carefully distinguish between real sexual weakness and sexual weakness which has supervened as a result of sexual excesses. For these cases belong to two entirely different categories.

If a strong, healthy, athletic fellow, endowed with a very strong sexuality, indulged daily one or more times for several years and has become impotent, then it isn't his athletics that is to blame for his weakness, but his excesses.

The kind of cases I have reference to are illustrated by the following brief reports:

Case 1. A. A., 28 years old. Was always fond of sports and athletics. Splendidly developed. All organs and functions in perfect condition. Formerly a leader and instructor in the Y. M. C. A. gymnasium. Married six months. Masturbated but very little at the age of 15, but having learned of the sinfulness of the habit gave it up entirely. Had pollutions about once a month or once in two months. Had occasional sinful desires, but would overcome them by brisk long walks or violent exercises. Gradually his will became so strong that it became easier and easier for him to repress his desires. On his wedding night he discovered, what he never thought of suspecting, that he was impotent. Libido is present, erection comes readily, but is weak and subsides almost immediately;

ejaculation takes place before *immisio* is accomplished. His wife is still a virgin. While this condition worries and humiliates him, his general health continues as good as ever. (In this case a complete cure was effected.)

Case 2. A. B., 30 years old. Policeman. The pride of the squad. Six feet four inches tall, a splendid specimen of animal manhood. Muscle plus, brain minus. Appetite enormous, bowels always regular, has never been sick a day. Libido practically nil — as far as he is concerned wouldn't care if he never went near a woman. But he sometimes yields to the temptations of sirens on the beat or the taunts of friends, and then he finds that it takes him very long to get an erection. Orgasm very weak and devoid of voluptuous sensation. Takes the thing good-naturedly, and would not come for treatment if he had not made up his mind that it was time for him to get married.

Case 3. A. B. C. Expressman. Powerfully built. Healthy in every respect. Drinks and smokes moderately. Can lift heavier trunks and do more work than any of his companions. 29 years old. Has never had intercourse. Tried it three times, but each time the attempt ended in a fiasco. Twice he had an erection, with almost immediate ejaculation; the third time all efforts to induce an erection proved futile.

Case 4. A. D. Physician, 35 years old. No healthier and handsomer disciple of Æsculapius ever takes part in the discussions at the meetings of the American Medical Association. Feels healthy in every respect — has always participated in games and sports. Condition: Libido

very weak (exclusively mental) and absolute impotentia erigendi.

Case 5. A. E. Cousin of Case 4. Civil engineer. All-round athlete and thorough horseman. Condition same as in previous case.

Here we have cases from different stations in life which well illustrate the co-existence of sexual weakness with perfect physical health, nay with a thorough, athletic, above-the-normal development of the body. Per contra, we often see poorly developed weaklings, suffering with various diseases, who are very powerful sexually, both as regards libido and potentia.

Case 6. Mrs. X. Twenty-nine years old. Married one year. Husband complains that she is perfectly frigid, like a wooden Indian. He is very much disappointed, as what attracted him to her was her well-developed muscular body, healthy outdoor complexion, fine bust, etc. Everything in her suggested strong sexuality, which always had a great fascination for him. She was a fine pedestrian, fond of all outdoor sports, and enjoyed magnificent health. Was never sick in her life. And still she was completely anesthetic. Confidentially she tells me that she never understood why other women were so crazy for men. Assures me that she has never masturbated, and I fully believe her. Whether her sex instinct is simply dormant and will awake later — in some women it awakes quite late, at 35 or even later — or whether she will stay forever frigid, remains to be seen. But the case is illustrative that in women as well as in men a strong well-developed body does not always go with a strong sex instinct. I know many healthy, buxom women who are sexual nullities. On the other

hand, I am often afraid of the thin, pale, anemic, somewhat dingy-complexioned girl or woman, for she is very apt to be a passionate, burning, unquenched, if not unquenchable, volcano. Her very thinness, paleness, anemia and dingy complexion are often the result of her strong passionate nature remaining unsatisfied or only partially satisfied.

It is well to bear in mind that the sexual function is a function per se, having its own centers in the brain and spinal cord, and its strength or weakness is not necessarily related to or dependent upon the strength and weakness of the body in general, and a splendid specimen of humanity may be and frequently is a pitiable failure *in rebus sexualibus.*

CHAPTER THIRTY

A SUMMARY OF THE MOST COMMON TYPES OF SEXUAL DISORDERS

The types of sexual disorders which come under the eyes of the sexual specialist are endless in their variety, diversity and complexity of their symptoms. He may see a thousand cases, and not two of them exactly alike. One hundred cases may be classified under the same diagnosis, and still they may, and usually do, present certain differences and peculiarities, which require modifications in the treatment, modifications which are sometimes of a diametrically opposite character.

The types of sexual derangement proper, that is derangement connected with the sexual act, which the sexual specialist sees most frequently are of seven kinds. (a) Lack of libido. The patient complains that he has no desire for women and doesn't care at all for sexual relations. He is able to have erections, but when he does have intercourse, the act affords him no pleasure. (b) The same as (*a*) only in addition to the lack of libido, he is unable to have any erections. (c) Has a normal or even strong libido, but is unable to have any erections. (d) Has normal libido, normal erections, but the ejaculations are premature or precipitate, taking place soon or immediately after or even before intromission. (e) The patient has normal libido, normal erections, normal ejaculations (though as a rule they are premature), but his complaint is that he derives no pleasure from the act;

when the discharge of the semen takes place he has no sensation whatever, as if the urethral canal were anesthetic. In some cases, the matter is even worse, for instead of a simple lack of sensation, there is a feeling of scalding or burning, during the passage of the semen. (f.) There is libido and good erection, but the ejaculation takes abnormally long, until he and his partner are exhausted, or fails to make its appearance altogether. (g.) The man has no libido, no erection, no ejaculation, and if by various manipulations a slight ejaculation is effected, it affords no pleasurable sensation whatever. Sex does not exist for him.

The above five classes of cases will constitute a large proportion of the sexual specialist's practice. The rest will be cases of masturbation, night pollutions (very many), day pollutions (comparatively few), prostatorrhea, urethrorrhea, spermatorrhea, painful ejaculations, sterility, which we find is due either to aspermia or azoospermia or necrospermia, disagreeable effects following the sexual act, such as severe headaches, migraine, nasal congestion rendering breathing difficult, cardiac palpitation, pain in the back of the neck, pain in the back, confused mind and inability to work or concentrate the mind, heaviness in the legs, sharp shooting pains in the urethra or the prostate, neuralgia of the testicles, etc; and last but not least, cases of sexual neurasthenia (vast numbers). The balance will be made up of cases of priapism, excessive libido (satyriasis, nymphomania), fetichism, sadism, masochism and homosexuality, and the various severer psychopathies, which take the patient out of the normal class, and render him a fit subject for an asylum for the insane.

I will present briefly and synoptically a few cases from my practice, which will form a sort of summary of the varieties of sexual weakness. Here and there, I will include a hint about the treatment and the result of the treatment.

Case 1. Twenty-four years, very intellectual. Masturbated from 14 to 19, about 3 times a week. He then read in a quack booklet about the terrible results of this vice, and he gave it up suddenly. Almost immediately after he began to have pollutions, once, twice and three times a week. When this kept up for about six months he consulted the family physician. The latter told him it was "nothing," it was a perfectly normal phenomenon, and prescribed potassium bromide in large doses. This helped the pollutions; they were reduced in frequency to about once a week or once in ten days. This condition lasted for several days after he discontinued the bromide. But then the pollutions came back worse than before: four to five times a week, then every night and sometimes two or three times a night. He again began to take the bromide, but this time it had no effect. If anything, it made matters worse. It certainly depressed him and ruined his digestion. Other remedies — chloral, lupulin, camphor monobromide were tried with no effect. Neither his masturbation nor his pollutions had affected him much. But now he was getting anemic and began to emaciate. The family physician was again consulted and this good man gave it as his deliberate opinion that the only thing for the patient to do was to get married. The patient demurred and consulted another physician, who gave the

same advice. In about six months the patient got married.

He found that he was able to have sexual relations, though the erections were not very strong and the ejaculations were somewhat premature, he thought. At least they took place long before the wife was satisfied. But he soon noticed that intercourse had a disastrous effect on him.

He would feel on the following day, and for two, three days after, as if he had been hit on the head with a club. He would be unable to concentrate his mind on any kind of work; he would feel a " vacuum " in his brain; the spine would be painful and weak, the legs heavy and hot, and he would feel wretched, anxious and quarrelsome. After three or four days the symptoms would gradually pass away. Appetite poor, bowels constipated. I saw that in this case the brain was overworked and the body undernourished; his body could ill afford the drain made on it by intercourse and by the loss of semen.

I ordered less mental work, and more or less forced feeding. Plenty of eggs, milk and meat. Complete abstinence for six months. Passed sounds and psychrophores once a week, once in two weeks. In two months he reported himself as feeling well. Intercourse had no bad effect on him. I told him to be very moderate. He disobeyed and in a short time he came back for treatment.

After he was practically well, I told him that there were types of men (intellectual workers particularly) who could not have sexual relations oftener than about once in two weeks, and he must limit himself to that frequency. He

has been living within these limits and is feeling well.

Case 2. Thirty-six years old. As far as he can remember has never had any sexual desire, has never masturbated, has never had any emissions. Once or twice by handling the genitals got some erection, which quickly subsided. Examination shows small, well contracted scrotum, but no testicles can be felt. Cryptorchid or anorchid. Penis normal and of good size.

Case 3. Complains exactly the same as preceding case, but examination shows the presence of two very small testicles. Also a congenital impotent.

Case 4. Masturbated as far as he remembers from the age of seven; maybe before. Kept it up right until about two weeks ago, when he got married. Sexual organs small and shrunken. Complete impotentia erigendi, but libido present. Completely well after eight months' treatment.

Case 5. Twenty-eight years old. Has masturbated steadily for 15 years (at least), since the age of 13, on an average 4 to 5 times a week. Testicles large and "puffy," but penis so small that it shrinks completely within the prepuce and is hardly visible. For the last two years the erections during the masturbatory act have been getting weaker, and now the seminal discharge takes place with the penis in an almost flaccid condition. Hasn't had a night emission in years. Never attempted intercourse, on account of strict religious bringing up. He consulted a physician, who advised him to get married "right away." But he has his doubts about the soundness of the advice and came to consult me. Some laymen have more common sense than some physicians. As he showed all the signs of impotence, I told him to get the

matrimonial idea out of his head "right away." If with persistent treatment, and occasional illicit relations, he should become fairly normal in a year or so, he should consider himself lucky.

Case 6. Twenty-five years old. Masturbated for ten years, on the average one day in the week, but three or four times during that day. From the age of 21 has also had relations about once a month. Is now losing the desire for sexual relations, but cannot give up the solitary habit. Has no night emissions, but any excitement, not necessarily sexual, brings on a discharge (slight) of spermatic fluid. Cold baths, psychrophores, $AgNO_3$ instillations brought about a complete cure in less than four months.

Case 7. Has a normal desire, but very great difficulty in getting an erection. Takes sometimes an hour of various manipulations and coaxing before an erection is obtained. After that he is all right. Masturbated for about 12 years steadily, practically every day or every other day, but has given up absolutely for the last nine months. Has not had a single night emission during that time. Strychnine internally. Counterirritant ointments to the penis, silver nitrate instillations and Zabludowsky's suction pump proved the most efficient agents in this case.

Case 8. Erections strong and quickly aroused, but ejaculations premature. Libido, however, exaggerated; performs the act (he "must") four or five times a week, and sometimes four or five times a night. Examination shows an extremely sensitive prostate and excruciatingly sensitive posterior urethra. I decide that this accounts both for the exaggerated libido and the premature ejacu-

lation. The result of the treatment proves the diagnosis correct. Because the cure of the local condition (by prostatic massage, psychrophore, and $AgNO_3$ instillations) cures not only the ejaculatio precox, but also the exaggerated libido, so that now he can get along very well with once a week, feels generally better in every way and enjoys the orgasm more than before.

Case 9. Has strong and frequent sexual desire and strong erections, but ejaculation takes place prematurely and wife is never satisfied. He derives pleasure from the act and feels well afterwards.

Case 10. Has strong and frequent sexual desire and strong erection, but ejaculation takes place prematurely, he has practically no enjoyment, and after the act he feels weak and depressed. The above two cases represent the two types of premature ejaculations which are discussed in a separate chapter in Part VIII.

Case 11. Has strong and frequent sexual desire, strong erection, but ejaculation takes place *immediately*, ante intromissionem. Derives no pleasure from the act itself and feels depressed after. Wife also dissatisfied and irritable.

Case 12. Is fond of female company, but has little desire for sexual relations. In fact, the little desire he does have is more mental than physical: "Would like to be as other men are." Has night emissions about once a month, but no erections.

Case 13. Practically a duplicate of the above, except that he does have strong erections (mechanical) in the morning. Is unable, however, to have any erections whenever he makes an attempt at intercourse.

Case 14. Has strong desire for women, and frequent strong erections when in bed in the morning. But at an attempt at intercourse he finds it very difficult to get an erection; and if erection is present it subsides at once, without ejaculation. In such cases an experienced woman and good wine are generally efficient remedies. Venus and Bacchus will accomplish more here than Aesculapius.

Case 15. Has strong and frequent sexual desire, fairly strong erections, and the ejaculation is not premature; but he has no sensation whatever during ejaculation, as if it did not take place at all. Wife feels satisfied, but he derives no enjoyment from the act. (We must bear in mind that a person may have strong sexual desire and the satisfaction of the desire may cause him no pleasure.) Strong silver nitrate instillations and cold water urethral injections brought about a cure very rapidly.

Case 16. Has strong and very frequent sexual desire, good erections, but the ejaculation is premature and causes him no pleasure. On the contrary, during the emission he feels a burning, scalding sensation in the urethra; and feels greatly dissatisfied afterwards. Nevertheless he cannot resist his desire the next time. Massage of the prostate, psychrophore and silver nitrate brought about a complete cure in two months.

Case 17. Strong libido, strong erection, but no amount of intercourse will bring about an ejaculation. He is obliged to remove the organ in full erection, and only in a few minutes to half an hour later does an atonic seminal emission take place. Examination shows tight stricture, admitting only No. 10 French.

Case 18. Exactly like preceding, but emission takes

place only after patient has fallen asleep. Has never had venereal disease, but was an excessive masturbator.

The above two cases illustrate an annoying condition, which is much more frequent than is generally believed. Whether due to a tight organic stricture, to a spasmodic stricture, or to some anatomic anomaly, the ejaculation fails to take place when the penis is in the erect condition, due probably to the fact that the congestion accompanying the erection occludes entirely the small lumen. And the semen is either not discharged at all, *i. e.,* remains in the seminal reservoirs, or is discharged into the bladder. When in the flaccid condition, the lumen is not so obstructed. (See chapter on The Causes of Sterility in Man.) Some men in their endeavor to produce an ejaculation continue the act until they are completely exhausted; they are covered with a profuse perspiration, the heart beats tumultuously, they are deathly pale — but all in vain. When they cease their efforts — an emission takes place.

These cases are readily cured. For instance, in the above two cases a cure was produced by small doses of atropine internally, belladonna suppositories per rectum before the act, and the passing of steel sounds half a dozen times. Case 17 is not yet cured of his stricture, but it is sufficiently dilated to permit of an ejaculation.

Case 19. Wife of Case 18. Complains of nervousness and irritability and headaches, caused, according to her statement, by unsatisfactory coitus. During the act the vaginal mucosa exceedingly dry and hot; the parts are aching for an ejaculation, and its failure to take place makes her very wretched, so that she cannot fall asleep for hours, and she is beginning to loathe the sexual act. Some

women derive no satisfaction from the sexual act, no matter how otherwise satisfactory, if they do not feel the male ejaculate. Such women cannot stand coitus condomatus. I advised the use of a lubricant, and this little expedient helped matters considerably, while the husband was being treated. Now they are in no need of any artificial lubricant.

Case 20. Age thirty. This case, as will be seen, might well go in the chapter on Coitus Incompletus or Masturbation. Strong, healthy, well-developed fellow. Has been normal sexually up to about eight months ago. Had sexual relations from the age of twenty on the average once or twice a week. Became engaged two and a half years ago, and about two months later began to have with his fiancée coitus externus (*sine intromissione*), and without any ejaculation. There would be no ejaculation at all, or there would be an ejaculation a little later, or he would have an emission in the night. His fiancée proved to be very passionate and he soon began to practice this kind of coitus practically every evening. As can be perceived this was practically nothing else than mutual masturbation. About a year ago he began to feel that the erections were not as firm as formerly, and subsided more quickly; it was also becoming more and more difficult to prevent an ejaculation. Still he kept up this method for some weeks longer, until one night he found he could get up no erection at all. He had gone from physician to physician, who gave him stimulants and so-called aphrodisiacs, but without the slightest benefit. All attempts, medicinal and erotic, to induce an erection proved fruitless. I ordered a six months rest without any treatment, but also without any sexual excite-

ment whatever. He demurred at first, but I told him that he ran the risk of becoming permanently impotent, and he agreed. The fiancée objected, but he explained matters to her, and she being sensible, consented and said that she would see that he ran no risk of sexual excitement. In about four months he came again, saying he felt the return of his old power, and asked for advice and treatment. Three months treatment brought about a complete cure; *i. e.* he began to have strong erections. He soon married and his condition is quite normal.

Case 21. Except for the finale, this case is practically a duplicate of the preceding one. I told him that he must have a complete rest for several months, but he, and particularly his fiancée, would not hear of it. The wedding day was definitely settled, and his bride would throw him over if he mentioned delaying the wedding for a year or even six months. I told him it was better she should throw him over now than after they were married. But he did not see it that way. And besides one doctor had told him that he thought he would be all right anyway after marriage. And so they got married. And I have heard that his life has been hell ever since. And there is talk of separation or divorce.

Case 22. Normal in every way, except that emission cannot take place unless he thinks and then deliberately fixes his mind on certain perverse scenes, which he lived through and witnessed in disreputable houses before he was married. His wife does not suspect what is going on in his head, but he considers it disloyal to her and wants to get rid of this "obsession."

PART IV

SEXUAL NEURASTHENIA

CHAPTER THIRTY-ONE

DEFINITION

Sexual neurasthenia is one of the most prevalent of diseases and the number of sexual neurasthenics is constantly increasing. Its manifestations are truly protean in character and, as will be seen, there is not a *single* organ in the body that, in the sexual neurasthenic, may not show pronounced symptoms of disease. And not only the patient's body, his psyche, his spirit is deeply affected. Definitions are often unsatisfactory things, and it is not easy to give a brief yet all embracing definition of sexual neurasthenia. I prefer to define it very simply: a condition of general bodily and nervous exhaustion resting on a sexual basis. After the symptomatology has been discussed, the picture of the disease will stand out clearly, and the reader will not be harassed by doubt as to what is meant by the term sexual neurasthenia. To us the sexual neurasthenic is so familiar that we can often recognize him at a distance. We know him by the way he walks in from the waiting-room to the office, by his greeting, by the way he begins to give his history.

The Etiology of Sexual Neurasthenia.

The causes of sexual neurasthenia may be briefly stated to be as follows: First: — Abuse and disease of the sexual organs. Second: — Our civilization. Third: — Heredity.

Under the first rubric we include in the order of their importance: masturbation, pollutions and spermatorrhea,

coitus interruptus, continence, gonorrhea with its various complications, especially posterior urethritis and prostatitis, and last and least, sexual excess. If I do not include impotence as a *cause* of sexual neurasthenia, it is because impotence and neurasthenia are both, generally, the concomitant results of antecedent causes, and also because impotence is often the result of neurasthenia.

Second. By the term civilization I understand both those agencies which exhaust and drain the nervous system and those which prematurely awaken and constantly stimulate and irritate the sexual instinct. The early school age, the excessive studies, the frequently recurring examinations (these are particularly injurious), the long hours at factory or shop, the struggle for bread, the still worse nerve-wrecking struggle for a career, the constant striving after money and more money or after fame, our poetry and novels, our theaters and vaudeville shows, the paint, powder and suggestive dressing of our respectable women, the solicitations of our non-respectable street-women, bad school companions and vicious acquaintances of both sexes — all these are factors which prepare a sexually neurasthenic soil.

But more important than any of the causes enumerated above is our moral-religious code concerning the sex instinct, which surrounds every sex manifestation with secrecy, and surrounds the satisfaction of the instinct outside of wedlock with great and *humiliating* difficulties. The repression of every sex manifestation is one of the greatest causes of sexual neurasthenia.

As to heredity, I do not ascribe to it the same importance that other physicians do. I have expressed my opinion

many times before, that the importance of heredity as a factor in disease has been greatly exaggerated, and in my opinion heredity plays but a very subordinate place in sexual disorders. It may be admitted, however, that children of neurotic and otherwise tainted parents are more apt to fall victims to various sexual irregularities, which may lead to sexual neurasthenia, and that on the other hand injuries which would have but little effect on descendants of healthy stock may bring irreparable disaster to nature's unstable step-children. Is any one of the causes mentioned in rubric one in itself sufficient to induce sexual neurasthenia? Is masturbation alone, for instance, sufficient to do it? Yes. If indulged in to great excess, it may without the aid of any other factors bring about sexual neurasthenia. But let us leave out the extreme excesses, the so-called furious masturbation. Let us take the various moderate degrees. Why does A who practiced masturbation pretty steadily, 3–4 times a week for several years, escape practically without any damage, finding on attempting intercourse his powers unimpaired, and his nervous system unaffected, while B who practiced masturbation only once or twice a week for about two years finds himself a confirmed sexual neurasthenic? Because A was born of healthy untainted parents and lives an easy, open-air, practically care-free life, while B has inherited a nervous constitution, has always led an indoor life and has studied hard from childhood, using up his last bit of reserve force in competitive examinations.

Why does C make a joke of his chronic protracted gonorrhea, his only regret being that he cannot indulge sexually as often as he would like to, while D is thrown

into the deepest distress, and the little hardly visible morning drop makes a gloomy hypochondriac of him? The same reason.

And so it is with all causes which we have enumerated above. They may in themselves in exceptional cases cause sexual neurasthenia, but they are much more likely to do it if they are operative in a man who has inherited a nervous constitution, and who lives the high-pressure, unhygienic life of our modern civilization.

The Symptomatology of Sexual Neurasthenia.

As indicated at the beginning of the chapter, the symptoms of sexual neurasthenia are exceedingly numerous and varied. We could start at the top of the head and go down to the soles of the feet, and we would find that every organ in between may be attacked, and may show symptoms varying from annoying to agonizing. But we will begin with the sexual and urinary symptoms, as they are more immediately and more frequently concerned.

Krafft-Ebing divides sexual neurasthenia into three stages. In the first stage the genito-urinary organs are locally affected and we have the various functional disturbances of coition and urination and pains in and around the genital organs. In the second stage the neurosis has extended to the lumbar cord and the patient complains of various symptoms pointing to spinal irritation. In the third stage we have a general neurasthenia. We will not adhere to this division, because while schematically very convenient, it is but seldom observed in practice. The symptoms of these various stages are generally interwoven, and those of the so-called second or third stage may make

their appearance before those of the first. We will therefore follow a more practical method.

Sexual Symptoms. Disturbances of the sexual system form of course a prominent feature of sexual neurasthenia. The patient tells us he is impotent and his organs have shrunk away. When we tell him to undress, we find in reality the penis very small, retracted, sometimes so completely "drawn in" as to be hardly visible, cold, livid and very hard. This hardness is rather characteristic; the hardness is sometimes that of cartilage. The scrotum is also well contracted and retracted, so that it is sometimes difficult to feel the testicles. The testicles are either normal in size or in extreme cases, especially where the neurasthenia is the result of excessive masturbation, considerably reduced. They are generally very sensitive to the touch, sometimes to such a degree that the gentle grasping of them between the fingers will make the patient deathly pale, his face will be covered with cold perspiration and he is ready to faint, and sometimes does faint. The small size of the penis is partly real and partly psychic. That the small size of the penis which we notice on examining the patient, is *partly* due to *psychic* causes, is seen from the fact, that it is generally only during the *first* examination that its shriveled condition is so apparent. It is the "shame" and nervousness before the new physician. At subsequent examinations the difference in the size of the organ is quite noticeable.

The same thing occurs at any attempt at intercourse, especially with a strange woman. To the patient's extreme mortification, at the critical moment, the penis in-

stead of getting erected, gets shrunken and shriveled and practically disappears.

In other cases on the other hand we find the external genitals greatly relaxed. The penis is rather large but soft and flabby, while the scrotum and testicles hang low down, and there is generally a slight varicocele on the left side.

Pollutions are frequent, and are generally atonic; in the further progress of the disease they become diurnal, and may be accompanied by spermatorrhea. Impotence is either absolute, the patient being unable to get any erection, or he has feeble imperfect erections, which subside quickly. The ejaculation is in the vast majority of cases premature, generally taking place even *ante intromissionem;* in a certain percentage, however, it is retarded, the patient being able to effect intromission, but the erection subsiding before ejaculation has taken place. A peculiar symptom the patients complain of is a burning, scalding sensation during ejaculation. The pleasurable voluptuous sensation which the normal man experiences during the passage of the semen is in them completely absent and the burning, scalding feeling combined with subsequent depression renders the act of coitus a very unpleasant function. And still they have an irritated, unpleasant feeling, what I would call a pseudo-libido, which forces them to indulge again and again. Others, however, in whom the libido is very weak or completely extinguished, may abstain for years from any sexual relations.

Masturbation, severe and uncontrollable, is often complained of. It may seem strange that masturbation which we gave as one of the *causes of* neurasthenia should here

be considered as one of the *symptoms* or *results* of it. But there is nothing incongruous in this. In many diseases, and in sexual disorders *par excellence,* a vicious circle is generally established and the original cause becomes but one link in the chain of symptoms. Masturbation is one of the principal causes of sexual neurasthenia; but after masturbation has succeeded in bringing about the neurasthenia, the patient's will is weakened, and he may become a helpless slave to the habit. While at the beginning the patient could control himself more or less, and the masturbatory act afforded him pleasure and satisfaction, he now indulges in it because he cannot help himself, because he seems to be impelled by a *force majeure,* and in spite of the fact that the performance of it gives him no pleasurable sensation, but on the contrary gives him a burning, unpleasant feeling in the urethra, and leaves him depressed and disgusted.

On some neurasthenics the effect of intercourse is very profound. It leaves them for a day, for several days, and sometimes several weeks, completely exhausted, both mentally and physically. Their brain is fagged out, they cannot concentrate on anything, their legs are weak, they fatigue quickly on walking, and suffer with severe cardiac palpitation.

Besides the functional disturbances in the sexual act, numerous symptoms manifest themselves in the genital organs which are very annoying to the patient and very trying to the physician. The skin of the penis and of the scrotum is hypersensitive and the patient often complains of various sticking or neuralgic pains. There is generally extreme sensitiveness to cold. Pains in the tes-

ticles are frequent as well as in the prostate. Sometimes the pains are only shooting and last but a second, at other times they are very persistent and may extend to the prostate, kidneys, legs and even feet. In some cases there is very severe itching about the genitals, the most careful examination failing to elicit any basis for this pruritus. Sometimes instead of the genitals the itching is confined to the anus. A very disagreeable and resistant symptom is hyperidrosis and bromidrosis of and about the scrotum. The odor of the perspiration is in some cases extremely offensive. The "hanging drop" symptom is to some patients the most maddening of all. Patients who suffer neither from urethrorrhea nor from spermatorrhea (in these disorders the drop *is* present) will imagine that their meatus is wet and that there is a drop there. Dozens of times they will examine the organ to find it perfectly dry, and still they will continue to be tortured by this apparently slight, but to them, very disagreeable symptom.

That the urethra, particularly near the meatus and in the prostatic portion, feels extremely sensitive, we have already seen in the chapters on masturbation, pollutions, etc. We have also seen that on the other hand in the later stages of the disease the urethra may become almost completely anesthetic to such procedures as passing a sound, for instance.

Urinary Symptoms. The act of urination is very much disturbed. The patients urinate very frequently, particularly in the daytime. They may have to get up nights, but that only in extreme cases. As a rule they sleep through the night very well and this is one of the

characteristic symptoms of the frequency of micturition in neurasthenics, which distinguishes it from frequency of micturition in other disorders, such as hypertrophy of the prostate. The frequency of urination is sometimes very great. Some patients have to urinate every hour, some every ten or twenty minutes. There is a little dribbling of the urine after each act and the patient will not feel fully relieved. They always feel as if there were some urine in the bladder which they are unable to void. While in many cases the urination is painless, in others there is associated with the frequency considerable dysuria and even strangury. Nervous retention of urine does occur, but is rare. The difficulty or inability to start the act of urination is another symptom worth while referring to. Some patients may have their bladder full of urine and still be unable to micturate in the presence of the physician. They must go in a separate room or behind a screen, and only then they are able to do it. Some can only start the act of urination at the sound of running water.

The Shiver. The shudder to which we referred to in the chapter on pollutions is here very prominent. It is either localized in a small portion, usually the center, of the spine, or it takes place throughout the entire spine. Occasionally the entire body would participate in the shiver, so that the knees suddenly flex and the head shakes. Since I became familiar with this symptom, I have made it a point to inquire of each sexual neurasthenic as to its presence, and in the largest percentage of cases the answer would be in the affirmative. Patients who present this symptom do not have it constantly. It appears with

some urinations; it is absent with others. In trying to solve this point — why patients experienced it at some urinations and not at others — I made a microscopic examination of a large number of specimens of urine, and I have discovered the following peculiar fact: Whenever the patients experienced the shiver, the urine contained semen and spermatozoa; whenever the shiver was not experienced the urine was usually free from spermatozoa, and it is my opinion that the shiver occurs only when there is an ejaculation, even ever so slight. As mentioned above, I pay great attention to this symptom, and its disappearance is a sign of positive improvement in a patient's condition. Its reappearance is an indication that the patient is "going back."

The urine itself undergoes considerable changes. In the early stages the patient as a rule passes very large amounts of urine, of a pale color and a very low specific gravity. It may be as low as 1002 and look exactly like water. Later on, however, the urine diminishes in amount and may even become much less than normal, of a dark color and high specific gravity. It may arouse in the patient and in the doctor fears of Bright's disease, but a chemical and microscopical examination settles the diagnosis. Phosphaturia is a very common symptom. And the urine is often loaded with phosphates. Oxaluria is also often present, though not so frequently as phosphaturia. The excessive amount of calcium oxalate crystals and also of phosphates is partly responsible for the scalding sensation which the patient experiences on urination. Due to the constipation and the intestinal fermentation, indican is usually present in large amounts, sometimes to

such a degree that on making the indican test, the urine turns actually black.

Of course the urine also presents the various appearances of underlying conditions: post-gonorrheal shreds, the masturbator's shreds, the "cloud" of spermatorrhea, etc.

Pains and Aches. Pains and aches in the spine, in the back, are among the most frequent, one might say *the* most frequent, and most annoying symptoms of the neurasthenic. Usually, it is not a pain, but just a constant dull ache in the small of the back or the middle of the spine, which is so exasperating that many patients say that they would gladly exchange it for an acute pain. The patient feels like rubbing his back against a door post, or a bedstead, or any other hard object and feels greatly relieved after a rough kneading or slapping or massaging of the back, or applying a counter irritant to the aching region. Sometimes the pain is limited to one side, in the kidney region, and may simulate renal colic so closely, as to bring the patient near the operation table.

Circulatory Symptoms. Among the symptoms on the part of the circulatory system the most frequent is palpitation of the heart. The least excitement or muscular effort is apt to cause it. In the night time if the patient wakes with a start, which he often does, the heart will beat very tumultuously. The pulse is frequent, often over 100 per minute, small, occasionally intermittent. There is a feeling of discomfort in the cardiac region; it is not a pain, but the patient feels like rubbing, pressing or supporting the precordium. Sometimes, though rarely, there is a real pain, simulating angina pectoris. And all these symptoms of course without any heart le-

sion; though again of course a sexual neurasthenic may also have heart disease, but that is another matter.

On account of the poor and irregular circulation, the patient's feet are often cold and clammy, so that he must sleep with his stockings on, even in fairly warm weather. His hands may also be cold and clammy and perspire readily. The blushing at the least provocation, and the frequent congestion of the head, also find their explanation in the disturbed circulation and innervation.

The respiratory tract is not affected. Some authors have described a dyspnea or asthma peculiar to sexual neurasthenics, but I have not come across any such instances in my practice. If the heart is subject to severe palpitation then the patient is naturally apt to become short of breath, but this dyspnea is then merely a part of the cardiac symptoms.

Digestive Symptoms. The digestive disorders occupy a prominent place. The appetite may vary from bulimia, which is quite common, to complete anorexia. And it is worth noting, that in spite of his excessive appetite, the bulimic patient may emaciate almost as much as the patient without any appetite. For the assimilation is poor, and the patient's metabolism is very rapid. Symptoms of dyspepsia are seldom absent: coated tongue, heavy breath, heartburn, which may be extreme, the patient declaring that he feels as if he had a burning coal in his stomach, hyperacidity, afterwards followed by hypoacidity, constipation, rarely diarrhea, belching of gas, borborygmi; occasionally there is some difficulty in swallowing. The digestive disorders are important, for it is they that generally send the patient first to the physician. A patient

has no hesitancy in consulting a physician about a digestive disorder, while he will wait for years — until his condition is unmistakable and intolerable — before he will seek advice for a sexual trouble.

The Special Senses. To the symptoms of the special senses we will refer briefly. The eyes as we mentioned already are easily fatigued, and the patients frequently suffer with eyestrain. Muscae volitantes, floating specks before the eyes, is not an infrequent symptom, extremely annoying to the patient. Itself the result of the neurasthenia, it often helps to aggravate it. The patients are extremely sensitive to noise. The tooting of automobile horns, the noise of vehicles, loud music, the chimes of church bells are a veritable torture to them. The sense of smell may be hyperacute, and sometimes there is a perversion of that sense: the patient will all at once smell iodoform, musk, etc. The sense of taste is but very seldom affected, though it may be in a very bizarre manner.

Work. In the extreme stages of neurasthenia the patient can do no work, either mental or physical. He *cannot* force himself to do any original mental work, it is an utter impossibility for him; and when he does force himself to do some routine mental or physical work, he gives out very quickly, and has to rest or lie down. In the earlier stages, he may be able to do very good and very intense work, but only by spurts. He cannot do anything steadily, calmly, placidly. He is not a plodder, and he cannot work systematically. If he writes a book, he is very likely to write the last chapter first, then a chapter from the middle, then the preface, then he may throw away the whole thing, and start on some entirely

different work altogether. But in the end, when he fits the pieces together, and fills up the gaps, he finds that he has probably accomplished more than the plodding systematic worker would. He will whip himself up, work without interruption sixteen to eighteen hours a day for several days in succession, and then his mind will become a blank, and he will be unable to do any mental work for several weeks. I am speaking here of mental workers, because they form a large percentage of sexual neurasthenics, and because my practice is largely among the intelligent classes, writers, artists, etc. It should be borne in mind, that some of the world's greatest writers and poets were sexual neurasthenics, but only neurasthenics in the earlier stages. Extreme neurasthenics do not write, and what they do write is not worth reading.

Some reader might stop here and ask: Isn't it possible that the long, rapid, hurried work exhausts the patient and is in itself responsible for many of the neurasthenic symptoms? And I will answer: It is. Cause and effect, I will emphasize once more, are closely interwoven in human pathology, and whatever the cause which urges the patient to consuming, long-houred labor, there can be no question that this labor itself tends to still further aggravate his original condition. But I do not believe that hard mental labor, within rational limits, will by itself cause sexual neurasthenia. There must be some additional favoring predisposing causes. I said, within rational limits. Of course, if a man works sixteen to eighteen hours a day steadily for many weeks, and has no fresh air, and on account of that eats poorly, and on account of the cerebral congestion induced by the hard mental work sleeps poorly,

he may break down, get general neurasthenia, which will in its turn bring about sexual neurasthenia. But this is work *beyond* rational limits.

The Mood. The mood of the sexual neurasthenic is extremely variable. The least pleasant occurrence or expectation lifts him up to the skies, the least unpleasantness throws him into the abyss of despond. But most of the time he is afraid of something. If you ask him to analyze his fears, to tell you himself what exactly he is afraid of, he is unable to do it, but still he is afraid that something bad is going to happen to him. He is either going to lose his business or his position, his rival is going to get ahead of him, or some misfortune is going to happen to a member of his family, or the house is going to be burglarized, or he is going to be arrested, etc. Sometimes the fear is vague and has no object, the patient is just depressed and afraid, and for this reason he avoids people in general. If the neurasthenic is not far gone, then a misfortune, an attack, a shock, or some great emergency may stir him to action, may awaken the rest of his dormant powers, and he may for a time surprise his friends by his unwonted strenuous activity. But unless he is at the same time subjecting himself to the proper treatment, he generally relapses into a condition of exhaustion, which is worse than the condition he was in previously.

One of the forms the fear is taking, is the fear of disease, i.e., the fear of getting sick. It is either the fear of typhoid, of heart disease, of Bright's disease, etc., but most generally it is the fear of locomotor ataxia or general paresis. This is particularly the case with our semi-cultured who have read a lot of quack literature, or who

have heard from their friends with little knowledge that those diseases were the result of youthful indiscretions. How many times have I heard the question: "Doctor, have I locomotor ataxia?" addressed to me by people with whom there was nothing the matter organically, and who did not present a single ataxic symptom. They feel like newborn, or as if a heavy load had been lifted from their brain, when they are assured and when it is proved to them that their fear is utterly groundless.

The neurasthenic has often hypochondriac ideas, but he is not a true hypochondriac. A true hypochondriac complains of ills and diseases for which there is no foundation, of which he has not a trace. The neurasthenic generally has grounds for his complaints, only he exaggerates his troubles; he magnifies a mild symptom into a terrible one; a slight disorder becomes a very painful one to him. But again how can we know? Perhaps, his *sensitiveness is so increased,* that what seems to us insignificant *does* cause him severe pain. For we must bear in mind, that the neurasthenic is generally hyperesthetic and his power of resistance is greatly lessened.

Phobias. The extreme cases of sexual neurasthenia may develop various phobias — fears of crossing the street, fear of being in a crowd, of being in a theater, of looking down from a great height. I have seen several cases in which the last symptom was very pronounced. One of my patients was a well-known chemist, who did excellent work and who stood very high in the profession. Nobody ever suspected or ever will suspect that there was anything the matter with him and still he was a sexual neurasthenic and he had a horrible fear of being in a

high place. He was a member of the Drug and Chemical Club, who have their clubhouse in the top story of a skyscraper in William Street. And he would suffer agonies if he would be invited by his partners and friends to sit down to dine near a window. His legs would shake, and the time of the meal would seem interminable. When by himself he would select a table as far away from a window as possible. Finally, he gave up going to the clubroom at all. He is however perfectly cured now and not only is he not afraid to stand near a high window, but last summer he climbed the Alps and crossed many glaciers — and laughed at his former fears.

The phobias are on the border line of psychoses; they form stepping stones to them. And sexual neurasthenics do sometime develop genuine psychoses. But here there is, as a rule, something else the matter: there is generally a hereditary taint. And after they develop a genuine psychosis they no longer belong to us. They belong to the domain of the alienist.

CHAPTER THIRTY-TWO

THE PROGNOSIS OF SEXUAL IMPOTENCE AND SEXUAL NEURASTHENIA

Leaving out of consideration the congenital and senile varieties, the prognosis in the majority of cases of impotence is favorable. That is, the large majority of cases of ordinary sexual impotence are curable. But it might as well be stated here as elsewhere that sexual impotence, equally with chronic gonorrhea, is a luxury in which a poor man cannot indulge. It is not a poor man's disease. The treatment of it is long and as a rule costly, and the poor man can not afford it. If a poor man is stricken with typhoid or pneumonia or cancer, there are plenty of hospitals for him to go to. No hospital will accept a patient who is suffering " merely " with sexual impotence, while the treatment that this class of cases receives at the dispensaries and at the hands of most general practitioners is positively worse than useless. I make this statement with a full understanding of the seriousness of its import. A bromide mixture, perhaps a little strychnine, or some worthless " aphrodisiac " tablets, is all the patient gets — and that without a consideration of the stage of the disease, the variety, without an endoscopic or microscopic examination. No wonder these patients keep on getting worse, become discouraged and drift into the hands of advertising quacks, or heart-broken and despairing decide to live out their days

without treatment. Sometimes suicide closes the scene.

But when a man is well to do, if he is his own master, if he has nothing to worry about, if he can afford treatments as often as necessary, which, however, should never be more often than twice a week, if he can have the various baths and hydrotherapeutic measures that may be necessary, if he can take a vacation if the doctor considers it indicated, if he can take an ocean trip or spend a month or two at the seaside or in the mountains if that is considered necessary, then we can restore the vast majority of our sexual impotents and sexual neurasthenics to good health. We may not restore them to their youthful vigor, but we can bring them to a condition which will be quite satisfactory to themselves and their wives. And in some cases we may even put the patient into a condition of vigor, superior to that that he ever was in before in his life. Patients who never had a satisfactory erection or experienced a proper orgasm before or always suffered with premature ejaculations, can with proper and patient treatment be made into "new men." It is the patient himself who generally uses this phrase: "I feel like a new man."

Never "guarantee" or even promise a cure. Only quacks guarantee cures. The only class of patients to whom a qualified though emphatic assurance of cure may be given is the class known as psychic impotents. Here we may assure a cure for two reasons: first, because a cure can be effected in practically every case and second — and this is the more important reason — the positive assurance of a cure is *a part of the treatment*. As soon as you assure the patient that you can cure him, he gains confidence in himself, and he may become sexually potent

in an incredibly short time. But in cases resting on a definite pathologic basis we are not justified in making positive promises which may be difficult or impossible of fulfillment. I never do. I only promise the patient to do the best I can for him, and I let him decide as to whether he cares to be treated or not.

Of course not all physicians can afford to exhibit the same independence towards patients, which is very unfortunate. I have seen patients suffering with paralytic impotence or cryptorchidism or absolute aspermatism, who were promised complete cures, to be made into perfect men, by their physicians. Such things tend to throw discredit upon our profession.

To give no guarantees, to refuse to make any promises, to refuse altogether to treat some patients, to show yourself financially independent, to make the patient understand that you are not after his fee and that to you personally it is a matter of indifference whether you treat him or not, is not only right morally, socially and professionally, but it is necessary for the successful treatment of your patient. For no sooner does an impotent, and particularly a neurasthenic patient perceive or suspect that you are anxious to make money out of him, than your usefulness is completely gone. You better give up the case at once.

One word more: Physicians as a rule make unsatisfactory patients. This is true of all diseases, it is particularly true of sexual disorders. They are too impatient, they are too skeptical, they do not follow instructions religiously, and they do not want to stand any pain. They are afraid of pain much more than the lay patient. I

have had an exceptionally large number of medical patients to treat and I confess I do not rejoice at the announcement that Dr. So and So wishes to come up for treatment.

CHAPTER THIRTY-THREE

THE TREATMENT OF SEXUAL NEURASTHENIA

To treat sexual neurasthenia successfully we must of course know the cause of the neurasthenia, and the type of neurasthenia we have to deal with.

The Two Types. To attempt to put each variety, each different type, of sexual neurasthenia in a special rubric and designate it by a special label, would be a thankless task. For the varieties are numberless and run into each other by imperceptible gradations. But still we are justified in recognizing two principal types of this disease. And the type to which our patient belongs will materially influence our prognosis and treatment. To define the two types briefly: In the first type the neurasthenia is produced by the impotence, or the neurasthenia and the impotence are the results of local causes; in the second type the impotence with its concomitant symptoms is the result of the neurasthenia. To put it in other words: In the first type we have the sexual trouble or abnormality first, the neurasthenia after; in the second type we have the general neurasthenia first and the sexual trouble after. And we must remember that there are numerous intermediary types, that is cases in which both causes are exerting their evil influence at the same time.

To give two illustrations:

Case 1. Age 30, almost completely impotent (very weak erections and immediate ejaculations), and typically

neurasthenic. History shows excessive early masturbation, then rather free sexual indulgence, then three attacks of gonorrhea; the last one about two years ago. The impotence has been coming on gradually during the past year, and the neurasthenic symptoms, as far as he remembers, during the past 6–8 months. His financial condition is excellent, he is entirely independent, he has nothing to worry about, his life runs in rather pleasant channels. Has always been gay and jolly, but lately has been feeling as if life was not worth living. Even before examining the patient I make my mental diagnosis of definite local trouble, with neurasthenia as a consequence. Of course, the impotence, in a man with theatrical connections, who was in the habit of having " all the actresses and chorus girls he wanted," and who now, under one pretext or another, must avoid them, is alone sufficient to induce neurasthenia. On examination I find an extremely congested posterior urethra, a swollen colliculus seminalis, also a slight stricture and an enlarged and extremely sensitive prostate; light pressure brings forth abundant catarrhal secretion. I give him a very encouraging prognosis, and massage of the prostate, urethral sounds and dilators, the psychrophore, instillations of weak silver nitrate solution, and then cauterization with the same solution but 20 per cent strong, bring about in six months a complete cure of both the impotence and the neurasthenia. There was practically no treatment of the neurasthenic symptoms proper.— Here we have a clear case of sexual neurasthenia resulting from local conditions, and disappearing with the cure of the local conditions.

Case 2. Almost complete impotence and severe sexual neurasthenia. Presents a goodly number of the symptoms described in the chapter on symptomatology. The history shows moderate masturbation between the ages of 14 and 17, then moderate indulgence between 21 and 25 at which age he married. Never had any venereal disease. Lived a regular, moderate life and was perfectly potent for 10 years. The impotence first showed itself in a diminished libido, then gradually the erections became very weak and the ejaculations premature. Has to urinate very frequently. Questioning brings out the fact that the last three years have been very hard for him. All his savings, which were considerable and which he invested very profitably in real estate, were swept away during the panic, so that now at the age of thirty-eight he finds himself as poor as he was at the age of twenty, and has to hustle for a living, when he thought he would be able to take it easy. Then a boy in whom they had great hopes turned out badly, and is a source of humiliation to the family. His wife also died a year previously. I at once recognized that I had to deal here with a case of neurasthenia to which the impotence and the other sexual and urinary symptoms were secondary. An examination shows the genital organs, the urethra and the prostate normal. Here I know the treatment will have to be principally of a general tonic and psychic character. If I do give him local treatment, it will be either for its psychic effect, or it will be only by the means of the psychrophore, because that has a general tonic effect.

Bearing these two general types of sexual neurasthenia in mind, the treatment of this disease becomes relatively

simple. Where the local symptoms predominate or where they are the cause of the disease, they must be treated energetically, before we can hope for a cure. At the same time general tonic treatment, proper diet and hygiene must not be neglected. Because, even if we do cure the local symptoms which brought about the neurasthenia, it does not necessarily mean that we have cured the latter. In many cases removal of the cause removes also the symptoms; but not in all; a local patch in the urethra which brought about neurasthenic symptoms may be cured, and the neurasthenia may persist, because the nervous system has in the meantime become so weakened or irritated that it requires treatment before it is brought back to its normal condition. While if the sexual trouble is secondary to a general neurasthenia, we have to turn our principal attention to the latter, without however altogether neglecting the former.

The local conditions or sexual disorders which may be responsible for sexual neurasthenia have all been described, and their treatment discussed. It is useless therefore to repeat that if we find a granular patch in the urethra it is to be treated and how it is to be treated, or if the patients have pronounced prostatitis, that that is to be treated, etc. We also discussed the treatment of the more or less local neurasthenic symptoms. But a few additional words may not be amiss in regard to the general treatment of the general neurasthenic condition.

It is here that psychic treatment is of great importance. The very first step in successful psychic treatment is the relation between the physician and patient. It goes without saying that this must be one of complete and un-

questioning confidence on the one hand and real sympathy on the other. If the physician finds that the patient is skeptical or even suspicious about his methods of treatment, and if he is unable to change this attitude quickly into one of complete confidence and reliance, he might as well give up the case. He will not cure or benefit his patient. Without confidence everything will be going wrong; even the local treatment, which in hundreds of cases has done you good service will in the suspicious and antagonistic patient seem to do actual injury. With complete confidence everything goes smoothly.

The first opportunity you have to establish or to increase the patient's confidence in you, is when you take his history. An experienced physician knows of course many or most of a neurasthenic patient's symptoms, and it is remarkable how his confidence in you, and his respect for you grows, if while taking his history, you yourself, without asking him, recount his symptoms. The fact that you seem to read him like an open book is an important factor in creating in him a high opinion of you. Next, the examination must be very thorough — every part of the urogenital system amenable to examination should be examined, digitally, by the urethroscope, bougie, microscopically, etc. Then a thorough general examination is to be given; the urine examined, the heart listened to, the blood pressure taken, the reflexes tested, etc. This thorough examination has a double object; first you may find out things which you did not suspect, and second it shows the patient that you understand your profession, that you take an interest in your patients, and that you are thorough; all of which increases his confidence in

you — a *sine qua non* in treating neurasthenic patients.

After having ascertained the patient's exact condition we have a good talk with him — and a good deal depends upon that talk. How many times have I seen a patient leaving the office looking ten years younger than when he came in, with a spring to his walk that he didn't have for years and a hope in his breast where everything was hopeless and cheerless for months, perhaps for years! How many times I heard them say: "Doctor, you have lifted a heavy burden from my mind, and I feel again that life is worth living." Some even go so far as to exclaim: "Doctor, you have saved my life." In this preliminary talk I explain to the patient the nature and stage of his disease — I have always believed in doctors taking their patients into their confidence — we tell him that we can help him only if we have his full coöperation. We tell him that we cannot *guarantee* to cure him — only quacks guarantee cures — but we will try our best and hope we will be successful. But of one thing we can assure him positively, that we will quickly benefit and improve him. We know that his will-power is weakened,— this is one of the characteristics of neurasthenia,— but we exhort him to collect all the little will-power that is left in him and that is perhaps lying dormant and to help us to cure him. I cannot improve his financial condition, I cannot remove the various external factors which cause him to worry and to be unhappy, but I show him the utter futility of simply worrying. I tell him that if he thinks that worrying will improve matters, that he may go on worrying from morning to night and from night to morning. But that useless, purposeless worry only makes matters worse, and is

very often nothing but a habit, the same as "fussing" and getting angry is a habit, from which one can break himself or herself, if he or she has a really earnest desire to do so. One would be surprised to see, what effect this commonplace, one might say, platitudinous little talk has. A goodly number of patients have told me that this was the turning point in their life. And many go away firmly resolved not to worry, once worry does no good, but simply to do the best they can. And this is already one good point gained.

Having gained the patient's confidence and assured ourself of his coöperation, we make an outline of the treatment proper. In some run-down neurasthenics, the first thing to do is to put them to bed for a week or two, and feed them up. It is almost a conditio sine qua non. Of course where the patient cannot possibly afford it, we have to do without it, but the treatment is so much longer, the results are so much slower in coming, that we should do our utmost to convince the patient to take this preliminary rest. The entire nervous system and the heart take a good rest, and the results of the other treatment are so much more striking. The diet should be nutritious, but not stimulating. Alcoholics should be eschewed. Plenty of milk, eggs and meat, but spices and condiments sparingly. While the patient is in bed, he should be given general massage, alcohol rubs or cold water sponging. If he cannot stay in bed, he should at least take the massage and the rubs. After the patient has had his rest, hydrotherapy will play an important rôle. At first we may have to order warm baths only; but gradually the temperature of the baths should be reduced, or the

warm bath should at least be followed by a cold douche. A thorough dry rubbing should follow each bath. At first the rubbing should be given by another person, but as the patient gains in strength, he should attend to himself. It gives him a certain kind of exercise. Exercise is generally prescribed for all kinds of neurasthenic patients, but in my opinion exercise with dumbbells and clubs, in a closed room, is of little benefit to neurasthenics. It often does more harm than good. Walking in pleasant and if possible new places is beneficial, but it must be done in moderation, increased gradually, and fatigue is to be avoided by all means. Driving or automobiling, sternly repressing any temptation of giving in to the crazy speed mania, is very beneficial, but under no circumstances should the patient himself hold the reins or the lever. There must be no strain, and the driver or chauffeur must be so competent and reliable as not to give rise to any nervousness on the patient's part. Sea, river or lake bathing is positively beneficial. Of course in the beginning a very strong surf must be avoided, and the patient must never be chilled. Bathing on cold, gloomy or drizzly days is therefore better tabooed.

If the patient must work for a living and must stick to an occupation which is distasteful or even hateful to him, we are helpless. But if the patient can afford it, he should select a congenial occupation, and if he can afford the time or the luxury of a hobby, he should be advised to indulge in it. It is even advisable to make him create himself a hobby.

Sometimes no measures will benefit a sexual neurasthenic until he has made a complete change of environ-

ment, climate or country. And there is no single measure so beneficial in sexual neurasthenia as is an ocean voyage. Its effects are sometimes truly remarkable. I have known cases, where an ocean trip across the Atlantic and Mediterranean, with a couple of weeks traveling in Europe, brought about a complete cure of both the sexual neurasthenia and the sexual impotence which was a result of it. And this without local or any other treatment. But if there is anything which shows conclusively the necessity for individualization, individualization, and again individualization in the treatment of sexual neurasthenia, it is the effect of ocean trips. For just as beneficial as an ocean voyage is in indicated and properly selected cases, so injurious it may prove in improper cases. I have known patients who were very greatly injured by an ocean voyage. If a man in the extreme stage of neurasthenia, unfamiliar with any European language, goes to Europe alone, without wife, relative or friend, has a rough voyage, is perhaps deathly seasick, has nobody to take a walk or to exchange a word with, then you cannot expect him to come home cured of his neurasthenia or impotence. The likelihood is, that both will be aggravated. But this does not militate against sea voyages being one of the sovereign remedies in sexual neurasthenia. But I will reiterate that it must be ordered with discrimination, in properly selected cases, at the proper time of the year, and only as a rule in company with somebody — a loving and congenial wife, or a congenial companion. That is all that is necessary to say about the general treatment of neurasthenia. As to the conditions causing neurasthenia, or the

various symptoms caused by it, their treatment has been discussed and the reader is referred to the respective chapters, particularly the chapters dealing with the treatment of pollutions and spermatorrhea and impotence.

The drug treatment of neurasthenia plays a secondary rôle and what we said about drugs in the treatment of impotence applies with almost equal force here. Except that we would emphasize the great value of strychnine. Some consider it *the* sovereign remedy in neurasthenia. Somebody has said: what morphine is in painful conditions, strychnine is in neurasthenia. I give it here, the same as in impotence, in large doses, and frequently hypodermically. It is here that the compound syrup of hypophosphites, the compound glycerophosphates and similar preparations prove signally beneficial. Arsenic often works wonders. The following simple combination is very good:

℞ Arseni Trioxidi .... gr. 1-30
Strychninæ Sulph. .... gr. 1-20
Calcii Glycerophosphatis .... gr. iii
Massæ Ferri Carbon......... gr. ii

M.f. pil. vel. caps. No. 1. D.t.d. xxx.

Sig.: One t. i. d. p.c.

Lecithin is useful and small doses of the thyroid and adrenal gland sometimes prove singularly and mysteriously beneficial. Perhaps we have no right to use the word mysteriously, for there is hardly any doubt now that, in a certain number of cases, sexual neurasthenia with all its symptoms may be caused by some disease or deficiency of the thyroid.

; we must always remember in the drug treat- rasthenia: to change the treatment frequently ,, only the form — from solid to liquid or vice — or the vehicle), and to intermit every week or two vo or three days altogether.

CHAPTER THIRTY-FOUR

REPORTS OF CASES

Of course nobody will imagine that any one patient is likely to have all the symptoms enumerated above. Though we have had patients, who at *various times* presented practically the entire catalogue, still the vast majority will only show some of the symptoms, perhaps half a dozen or a dozen.

While some sexual disturbance is present in all patients — this is a conditio sine qua non, for a perfect sexual system excludes the diagnosis of sexual neurasthenia — they are sometimes strongly overshadowed by the symptoms of the other organs. Thus in some cases the urinary disturbances will be so severe, as to make one think of tuberculosis of the bladder, hypertrophy of the prostate or stone in the kidney. In others the gastro-intestinal symptoms will predominate. In fact they will be the symptoms that will bring the patient to the doctor, and they will go from one gastro-enterologist to another, swearing at the specialists and scoffing at medical science because they are not benefited. In still others the circulatory symptoms will be so severe as to leave no doubt in the patient's (and in the average physician's) mind, that it is a case of heart disease (and if the patient is so unfortunate as to get into the hands of a physician who gives digitalis for every heart case, then he is sure to get worse, for digitalis is very bad for this class of patients). In still another

large percentage of cases the cerebral and general nervous symptoms will be in the foreground.

The description of a few actual cases will help to make the picture of sexual neurasthenia clearer, and serve to impress it on the reader's mind; they may help him to arrive at a correct diagnosis in instances where he floundered before.

Case 1. Lawyer by profession, 5 feet 10 inches tall, weight 120 pounds. Extremely emaciated — just skin and bones. Has the greatest difficulty in attending to his business, but whips himself up to do it. Every once-in-a-while however he is obliged to stay home a day or two. Severe and frequent headaches. Very pronounced dark rings around the eyes. One can see that the man lives on his nervous capital. Appetite very good, almost ravenous; slight belching and constipation alternating with slight diarrhea. The symptom, however, which annoys the patient most, and for which he came to consult me, is frequency of urination. He has to urinate every half hour, sometimes every hour, but some days every 15–20 minutes. He had been treated for this trouble, locally, by another genito-urinary specialist for about six months without any benefit. That specialist suspected tuberculosis of the bladder, which is not so surprising because the patient's mother died of tuberculosis and he himself was coughing slightly and gave the impression of a consumptive. The doctor did not inquire into the patient's sexual life, and the patient did not think it was necessary to refer to it. On asking him how it was in the night time, I received the answer that while he did not sleep well, he had no trouble with his urination. Seldom

that he had to get up even once. As will be noted by those who read the "Symptomatology of Sexual Neurasthenia" carefully, this is almost a pathognomonic sign of this condition. I went closely into his sexual history. He masturbated frequently from about 13 to 22, he then tried to break himself of the habit, and began to suffer with pollutions. Between the ages of 22 and 25 he would have two to three pollutions a night, and would masturbate about once in two or three weeks. At the age of 25 he began to have intercourse; it wasn't very satisfactory, and he would indulge only once in about three or four months. At 28 he got married — was told by his doctor it would be a good thing for him. Found himself practically impotent — just a feeble erection and an immediate ejaculation. Attempts intercourse about once a month — his wife is very "good," and doesn't mind it. But he still suffers with pollutions, about once or twice a week. An examination showed the posterior urethra congested and sensitive, and the prostate extremely so. The gentlest touch of the gland made him nearly faint. With very little local treatment, but by internal medication and the application of general measures as outlined in the chapter on treatment (first of all the patient was put to bed for two weeks, and then he went to the country for two months), he began to improve rapidly, put on twenty-two pounds in four months, and is now a perfectly well man. That is, perfectly well as far as his urinary trouble and general neurasthenic symptoms are concerned: his sexual power still leaves much to be desired, but he is improving right along, his pollutions have stopped, the erections last considerably longer, and in time

he may be restored to practically normal sexual power — though he will never be vigorous in this respect.

Case 2. Well nourished, inclined to stoutness, suffers with extreme dyspepsia and flatulence. Is "no good" for two or three hours after any substantial meal, no good physically or mentally. Feels so heavy that he must lie down; falls asleep soon, and wakes up in a much worse condition, with the face congested, heart palpitating, and all "a tremble." Severe persistent headaches. There is no pain in the stomach, but the organ is extremely distended after each meal. The ache in the back is constant. The tongue heavily coated. Has been treated by at least half a dozen physicians — general practitioners and specialists in stomach diseases. Has had gastric lavage, which made matters worse. Bismuth subnitrate and sodium bicarbonate are the only drugs from which he gets relief. It is settled with him and his physician that he is a sufferer from chronic gastro-intestinal trouble and that all he can expect is relief. He came to consult me on account of premature ejaculations which he had been noticing of late, but he hasn't a glimmering of a suspicion that his gastric trouble can have any connection with his sexual sphere. I begin to take his sexual history. He is forty. Masturbated moderately between the ages of 13 and 18; after that had moderate intercourse. Married at twenty-five. His wife has been rather exacting from the first day. For the first five years had natural relations, the wife using a douche occasionally. Had three children in the first five years. After that, that is for the last ten years has been practicing *coitus interruptus,* and practicing it frequently, for, as mentioned,

his wife was a rather exacting woman; up to a year or so ago his sexual power was very good. Even now the erections are good. His gastro-intestinal troubles date back about eight or nine years. To me this was a plain clue. To my mind the coitus interruptus was the cause of both the gastro-intestinal symptoms and the commencing impotence. The course of events and the rapid and remarkable success of the treatment fully justified my diagnosis. I ordered complete abstinence for a month, and then only natural coitus about once in five days. But I emphasized that the coitus had to be *perfectly natural* from the beginning to the end; he was not to use even a condom. The treatment I prescribed was of the mildest — just some arbutin granules. More as a placebo than anything else. For I wanted to be sure what effect natural coitus would have by itself. The change within two months was remarkable. The ejaculations improved, the headaches disappeared, the gastro-intestinal symptoms became much milder, and in six months more he was a well man.

Case 3. Has masturbated since the age of twelve. At the age of 23 had intercourse for the first time, and during the very first initiation night got a severe gonorrhea, with numerous complications, which lasted about five years. In fact, it is not quite cured now, and he is now thirty-six. He still has numerous large shreds in the urine, the posterior urethra is congested, inflamed and bleeds readily, the prostate is enlarged, tender and a large amount of prostatic fluid of a catarrhal character is expressed by the gentlest massage. Has never attempted intercourse since his first venture which had such disastrous results, but suffers with pollutions 4–8 times a week, sometimes

2–3 times in one night. Also masturbates occasionally, chiefly when excited or annoyed by something. During the last six months the pollutions, which are completely atonic and unaccompanied by any dreams, have increased in frequency, and he now also has diurnal pollutions and a frequent oozing of semen. (This on examination proves to be chiefly prostatic fluid, but now and then it contains spermatozoa; it is thus a case of true spermatorrhea.) The patient is a truly pitiable object. He was the owner of a drug store, but he could not keep it up, and it was sold at auction. He started clerking in small drug stores, but could not keep a position for any length of time. Now he is "relieving" and makes his 6–8 dollars a week, as he cannot work more than 2–3 days out of the seven. He is timid, afraid of everybody, never looks anybody in the face, walks with a shuffling gait, is afraid that everybody can notice at once what is the matter with him, is suspicious and quarrelsome, his memory is exceedingly weak, talks slowly, hesitatingly, has severe headaches, pains all along the spine, his legs bend under him, fatigued after the least exertion, appetite exceedingly poor, constipated, the face jaundiced and pimply, breath heavy. Is afraid people are after him and want to ruin him and cries readily when he tells me his troubles. Claims that he doesn't sleep at all, no, *never sleeps at all,* not even for an hour (which of course I don't believe). Claims that he wishes to die, but is afraid to ride in an elevated train, because the train might fall down and he might be killed. (But so it is with many hysterics and neurasthenics: They wish to die, i.e., they say so, but they have a deathly fear of anything that might help them to realize their wish.)

He had been under my treatment for a year, before he began to show any signs of improvement in his general condition. His sexual libido remained about the same, but the pollutions practically ceased. He was called out West by a brother and I lost track of him.

Case 4. Miss A. Thirty-three years old, from a fine well-to-do family. An extremely sympathetic girl, with a delicate face, on which the lines of suffering are clearly and painfully visible. She is very chlorotic, lips bloodless, complexion dingy, chest flat, somewhat stoop-shouldered. Complaint: Terribly nervous and hysterical. Has been suffering for ten years or more. I am informed that at about the age of twenty she was stout and exceptionally healthy. She began to lose ground gradually. She has become so nervous that the least little thing makes her cry for hours at a time. Her appetite is wretched, and her insomnia is extremely obstinate. She has been going from doctor to doctor, who had given her every variety of iron preparations, strychnine, arsenic and bromides; for the insomnia she was given gradually increasing doses of sulphonal, trional and veronal. But all these were of no avail whatever. Not that they did not do her much good, but they did not do her any good, except the hypnotics, that procured her an occasional hour or two of sleep. She was sent away to a well-known sanitarium, and while the hydrotherapeutic measures seemed to improve her condidition, the improvement was but temporary. During her hysterical attacks she would scream in a most unearthly fashion, tear her hair, knock her head against the bedpost, and then would fall exhausted as if in a dead faint. All about her would get frightened, throw cold water on her,

give her aromatic spirit of ammonia, etc. At first they would run for the doctor, but now they are used to these attacks. She has developed recently a pronounced anxiety neurosis. She is afraid of some great calamity. She is also afraid to be in the dark, to be alone in the room, to cross the streets, to be in a crowd. Her people are afraid that her mind was going to give way, but I don't find it so. She is very rational, and a bond of sympathy is soon established between us. Discreet, sympathetic questioning brings out deeply hidden secrets. Seeing that I know her trouble, she tells me what she says she never told to any other living person. For the last ten or twelve years she has been suffering the tortures of hell from unsatisfied sexual longings. The desire would become at times so strong that she simply would not know what to do with herself, she would become as insane, and this would often end in a hysterical attack. Close investigation brought out the fact that she *never* masturbated. Whether the various doctors who treated her knew or suspected what was the matter with her or not she doesn't know. She thinks that two or three of them knew. She also told me that she was annoyed or tortured night after night by numerous dreams, some bizarre, some horrible. While I recognize the immortal merits of Freud in having focused forcibly the attention of our profession — and of the intelligent laity — on the relation between sexual abstinence and the various neuroses, I am but a luke-warm Freudian in the realm of dreams. I believe that in the dream interpretation Freud and still more so some of his disciples go to extremes, and say things which are foolish, absurd, bizarre, fantastic and grotesque. But in this case it did not require a Freudian

interpreter to see that the dreams were all plainly and grossly sexual.

I told my patient that it was useless for her to come to me for treatment; I refused to prescribe for her and told her that there was no drug in or out of the pharmacopeia, no physical measure, no electricity, no hydrotherapy, no psychic influence that would be of the least avail to her. There was but one remedy that would help her and that remedy she knew as well as I. And with that we parted very good friends. She thanked me for my frank talk and was glad that I did not give her any medicine. She always felt that in her case they were just a humbug. There are thousands of such cases going from doctor to doctor, receiving arsenic, bromides and hypnotics, or vibratory treatment or high frequency currents, when as a matter of fact all they need, and the only thing they need, is a normal, natural vita sexualis. But how many doctors have the courage and honesty to refuse to "treat" these cases, but just tell them the truth?

Case 5. Stout, buxom healthy woman of thirty-five. Married ten years. By appearance nobody would suspect there was anything the matter with her, but has been suffering for the last two years with obstinate insomnia, which has been gradually getting worse. Is irascible and given to fits of deep depression and melancholia. Investigation discloses the fact that her husband, who is ten years older than she, has been gradually getting weaker sexually and is now almost impotent. His erections are good, but the ejaculation is precipitate. The first years of their married life he was quite normal, though not very vigorous. I tell the couple that it is he and not she who needs treat-

ment. Six months' treatment of the husband bring him back to a fairly normal condition, and with his improvement there is a complete change in her temper and demeanor and she declares herself quite happy.

Case 6. The history of this case was related to me by a fellow practitioner, Dr. A. S. A beautiful refined young woman fell in love with a refined artistic young man. There was objection to their union, so she eloped with him and they got married. Very soon she began to ail with all kinds of ailments, physical and psychic, for which all treatment proved useless. The husband, whom she loved devotedly, died suddenly and left her unprovided. After struggling for two or three years, trying to make an independent living, she got an offer of marriage from an ordinary well-to-do business man, much beneath her intellectual and socially, and several years older than herself. She felt no love for him, but she was tired of struggling, she wanted a home, and she accepted. Very soon after marriage her health and spirits underwent a remarkable transformation. She was improved in every respect, and her neurasthenia disappeared without a trace. The doctor's confidential questioning brought out the fact that her first husband was quite weak sexually, almost impotent, while her present husband was very vigorous in this respect. And what is more her feelings for her present husband also underwent a transformation! She is quite in love with him now.

NEURASTHENIA AFTER GIVING UP MASTURBATION.

Case 7. Age 24. Came to me complaining of extreme depression and anxiety. Is in constant fear that some-

thing terrible would happen to him. He is going to get dangerously ill, he is going to lose his job or he is going to be arrested. "Have you done anything that might make your fear of being arrested justified?" No, he has committed no wrong, he has done absolutely nothing to bring him within the clutches of the law, and nevertheless he is afraid. He is also afraid he may commit suicide. A close *questionaire* elicits the fact that he had been masturbating for about ten years. He did not feel any particularly evil results until about a year ago, when the *voluptas* connected with the act was becoming markedly diminished, and he would get headaches afterwards. About four months ago he read an article in a medical journal about the evil results of masturbation, and that the habit was apt to lead to complete impotence. He determined to give it up. It was not particularly difficult for him to do. He "fell" twice or three times after his decision, but for the last three months he did not indulge in the habit even once. But very soon after he broke himself of the habit, he began to feel great psychic depression, which has been increasing in intensity. Of course he was very much surprised and chagrined. He thought that after giving up the habit he would at once feel better; instead he has been feeling worse.

I explained to him that this was not such a rare occurrence. Many masturbators feel very much depressed after the sudden giving up of the habit. It is the same with all habits. The alcoholist, morphinist and cocainist suffer in a similar manner on the sudden withdrawal of their drugs. The depression may be of a degree dangerous to life. Bad as a habit may be, if the body gets used

to that habit during a number of years, the sudden breaking of the habit may have unpleasant results.

Apparently the body gets a certain stimulation from the masturbatory act, the absence of which stimulation brings about the depression. We see the same thing in people who have been used to regular intercourse; if they are obliged for some reason to give up sexual relations for any length of time they may feel very depressed and despondent. I am not referring to ordinary unpleasant sensations connected with complete abstinence in healthy people, who had been leading a regular sexual life, but to the deep psychic depression, which sometimes assumes dangerous degrees.

This is a point with which the general profession is not familiar, and I take this opportunity to bring it to its notice.

When we tell a patient that his case is not the only one in the world, that it is not unique, that it is something which we see often, that there is nothing mysterious in it, we thereby alone help our patient considerably. He feels relieved and hopeful. I told the patient he should not worry, should persist in refraining from masturbation, prescribed the compound syrup of hypophosphites and cannabis indica, and ordered warm baths, followed by cold ablutions; in a short time the patient was free from his depression, and some weeks later he was living a normal moderate sexual life.

"THIRD DAY" DEPRESSION.

Case 8. Dentist, 34 years old, very intelligent, married ten years. Has not been feeling very well for the last five or

six years. Has a big practice, which keeps him in the office the entire day from 9 A. M. to 8 or 9 P. M. The peculiar feature of his case, however, is that *Tuesday* is his worst day. He is quite sure that it is not imagination with him. He thought at first it was purely accidental, but the thing has been going on for nearly two years, and it has happened every Tuesday, with the exception of two months in the summer and the improvement in this period he ascribed to treatment he received. His condition on that day he described as most wretched and miserable. His head felt empty and he had an iron band around it, his throat was dry, his legs were hot and heavy and it was very difficult for him to stand and to attend to his work. He had to lie down several times during the day. He felt a severe pain in the back, or rather a nagging, drawing sensation which compelled him to rub it, to have it massaged, to apply counterirritant plasters or ointments. And his mental condition was worse than his physical. He felt terribly depressed and anxious, and while he did not care to commit suicide, he was sure that he didn't care whether he lived or died. I asked him if he was sure that he felt that way on Tuesdays only, and he answered emphatically in the affirmative. He said he hoped that I at least would not doubt his veracity or consider him crazy, as some doctors whom he consulted had done. He consulted, according to his statement, at least half a dozen physicians, among them one eminent internist and one specialist in neurology and psychiatry. The results of the treatment were either nil, or merely palliative and temporary. Nobody asked him about his sexual life. From a description of the symptoms I saw that I had before me a sexual neurasthenic. I

asked him how often he indulged in sexual intercourse and he said once a week. Further inquiry elicited the fact that that once was always on a Sunday. Week days he worked hard until late in the evening, and he came home very tired, but Sundays he worked only until 1 P. M., and the afternoon he spent leisurely, and it was in the afternoon or evening that he would indulge. It became a habit with them, to which they, his wife particularly, were looking forward. This explained the whole situation. Our patient belonged to that numerous class of sexual neurasthenics in whom the symptoms of exhaustion and depression come *on the third day* after coitus.

In some neurasthenics the depressing effects of intercourse come on almost immediately, in others on the next day, but in a large proportion of cases they do not make their appearance until the third day. As to the intervening time, cases differ. Some patients feel better and buoyed up during the first or first and second days, and only on the third day the exhaustion and depression takes place; others feel neither better nor worse in the interval. The reason why he felt better for two months in the summer was readily explained by the fact that during that period his wife was away in the country. Examination demonstrated the presence of an inflamed patch in the posterior urethra and a congested prostate, both probably brought on by early masturbation and subsequent coitus interruptus. I ordered the patient to abstain at least for six months as a *conditio sine qua non,* to which condition he readily assented. The posterior urethra and the prostate were cured without much difficulty (sounds, silver nitrate instillations, prostatic massage and rectal cold water irrigations), he

was given general tonic and hydrotherapeutic treatment, and much before the six months of penance were over he felt himself a different man. His sexual relations are not followed now by any symptoms of exhaustion or depression, and the once dreaded Tuesday now has no terrors for him.

OOZING OF SEMEN AFTER THE ACT OR SPERMATORRHEA POST COITUM.

Case 9. Has strong and frequent sexual desire, erections perfect, ejaculations somewhat premature, orgasm highly satisfactory, but only one trouble. After the act there is kept up for a longer or shorter period an oozing of semen. He will wake up two or three hours after the act and the semen will still be oozing. He feels very much exhausted and depressed the following day or two, and he was sure that the exhaustion and depression were due only to the leaking of the semen. Before he began to suffer with the leak, the sexual act was never followed by any unpleasant by-effects. Questioning brought out the fact that this oozing would take place only when he would fall asleep immediately after the act, as he was in the habit of doing lately (and as is usual with so many men). If he did not fall asleep, or if he performed the sexual act in the morning, or day time, no oozing would take place. The treatment for this condition, which I would designate as spermatorrhea post coitum, was obvious. I advised him not to have sexual relations on going to bed, when he was tired out and the entire muscular system was relaxed, but in the morning or in the daytime. Should he happen to do it at night, then to get up and wash himself all about the genitals with

cold water. He followed the advice and he had no further trouble.

Case 10. This case is practically a duplicate of the preceding one, with the exception that the advice though strictly followed was only partly effective. While there was not so much oozing, still there was some. Evidently the ejaculatory ducts became so atonic that once opened, they did not have power to close tightly. Here several treatments with the psychrophore and instillations of silver nitrate brought about a cure.

CHAPTER THIRTY-FIVE

THE RELATION BETWEEN IMPOTENCE AND SEXUAL NEURASTHENIA

I am devoting a separate brief chapter to the relationship that exists or doesn't exist between impotence on the one hand and neurasthenia or hypochrondriasis on the other because of the great confusion on this subject in the minds not only of the laity but of the medical profession. The average physician thinks that impotence is necessarily connected with neurasthenic symptoms; some think of the two terms as synonymous. One doctor even wrote an essay entitled Sexual Neurasthenia, when as a matter of fact the whole essay deals with sexual impotence. Let us get some light on the subject.

While of course every case of sexual neurasthenia is connected with some derangement of the sexual organs or centers — the very name sexual neurasthenia implies that, — it is in the highest degree erroneous to think that every case of sexual impotence exhibits some neurasthenic or hypochondriac symptoms, or any disturbance in the general health. I am not speaking of physiological impotence; that the impotence before puberty and after sixty-five or seventy is perfectly physiological and is not accompanied with any psychic disturbances needs no emphasis. But I speak of pathologic impotence, and I wish to emphasize that men who have become prematurely impotent, at the age of 40, 35 or earlier, or men who never in their

life were potent, may be perfectly healthy, physically and psychically.

I know men of 40 who are impotent and are perfectly content with their impotence. Their health is good, they do not show a single neurasthenic symptom, they attend to their work as well as formerly or better, and they would not think of subjecting themselves to treatment, if their wives did not urge them to. If they have no wives they take no treatment. I know men of 25 and 30 who are congenitally impotent, relatively or absolutely so, and who, contrary to the shambling, dejected, depressed sickly type of sexual weakling, are strong, active, energetic, intellectual and full of the joy of life. They may have occasional regret at their disability, and their inability to have a family, but looking at the thing from a common-sense point of view and seeing that there are other fields of human endeavor and conquest beside that of sex, they devote themselves whole-souledly to a certain line of work and are generally successful. And what is more, some of those congenitally impotent men have great success with the ladies, for lack of libido sexualis and impotentia coeundi does not at all imply lack of desire for the company of the gentle sex. But of course the success is of a platonic character, more or less. May be one of the secrets of their success with a certain class of young ladies is that the latter soon find that they are "perfect gentlemen" and that they never attempt to go too far.

Let us therefore remember that while most sexual weaklings are as we described them and present the symptoms mentioned in the chapter on sexual impotence, there is a goodly number of sexual impotents who do not present

any neurasthenic or hypochondriac symptoms, who are not objects of pity, who do not spend their lives bemoaning the cruelty of fate, but are good hard workers and manage to get a good deal of joy out of life in other avenues than those of sex.

CASES OF IMPOTENCE WITHOUT NEURASTHENIA

The reports of the following cases will demonstrate that impotent men and women need not have a single neurasthenic or hypochondriac symptom.

Case 7. Successful lawyer and journalist. Thirty years old. In excellent health and always in good humor, always jolly and a good story teller. A great favorite with everybody, especially with the ladies, whose company he decidedly prefers. Is considered a Don Juan, is reputed to be very successful with the fair sex, and to this fact is attributed his happy mood and perennially jolly countenance. When he called me up to make an appointment, stating that he wished to consult me professionally, my first thought was that at last X's rather loose life brought him into trouble. My surprise was very great when he told me his story. He has never had sexual relations, and has but very, very seldom a weak, imperfect erection. He enjoys female company very much, but not in a sexual way. He likes to be in the company of girls and women, talk to them, walk with them, even flirt with them, but he has no carnal desires. Perhaps most women like him just for this — because he is so gentle, manly, never hinting at anything improper. He has never felt unhappy about his condition, in fact he rather felt pleased that he was free from something which

seemed to play such an important rôle in the lives of other people, and that he had to make no entangling alliances, had to run no risks of venereal infection, no expense, etc. The reason he came for treatment was that he met a young woman for whom he cared more than for any woman he had ever met before and she seemed to care for him. And if possible, he would like to marry her. And he was getting tired of his bachelor's life, and would like to establish a home. He had the means to support a wife and family in comfort and affluence. If, however, nothing could be done for him and I would not advise him to marry, he would resign himself into his condition without much chagrin, and he would go on living as he had up to the present. There was not a suspicion of neurasthenia in the man, nor a trace of depression and his physical health was perfect. In him certainly the impotence was not connected with neurasthenia.

Case 2. The following case differs essentially from the previous one in the fact that this patient's impotence was an acquired one. A. B., 42 years old. Began sexual life very early. As far as he can remember he started to masturbate when he was nine or ten years old. He kept it up until the age of 15, when he began to have normal sexual relations. Between 18 and 22 he indulged very frequently, excessively. Then for 3 or 4 years he was more moderate. At the age of twenty-six he married and for ten years he led a very active sexual life. His health has been perfect right along. About six years ago he began to notice a gradual weakening in his libido and in his erectile power. This weakening has been slow and gradual, but uninterrupted, until now he is completely impotent. He has prac-

tically no desire whatever, and it is almost impossible for him to get an erection. To the question whether his lack of desire is perhaps only towards his wife, and if he has any desire towards any other women, he answered that it was quite the contrary. His affection for his wife was continually increasing, while he had no use whatever for other women. They rather repelled him; he said that his present feeling towards the female sex was one of oversatiation; he felt as he used to after he had coitus several times in succession. As stated before, his general health was always good and has remained so up to the present moment. To the query, if his impotence affected him psychically, if it made him feel depressed and unhappy, he answered: Not at all, *on the contrary*. When I asked him what he meant by "on the contrary," he said he felt a kind of satisfaction that he was through with it. He had enjoyed it enough, a quarter of a century of sexual activity was sufficient, and that he was glad that he could devote himself to his work undisturbed. He had noticed that for the last four or five years, since he had been indulging very little, he could attend to his work better, could work longer without fatigue and he felt better in many ways. To the question, what brought him to me for treatment, he gave the expected answer: The wife. As so often happens, and as I have seen it in hundreds of families, just when the wife has fully awakened, just when her libido is at its height, the husband's libido begins to burn dimly or becomes extinguished altogether, and his erectile power becomes nil. As I mentioned, I believe, elsewhere, I have to treat a very large number of men who would not think of going to a doctor for treatment if not forced to it by chivalry to their

wives or by the direct demands of their wives. Sometimes these demands are not couched in very gentle language either, and sometimes they are accompanied with threats, either open or implied, that they would have to look around for another man.

Case 3. Mr. and Mrs. A. A happily married couple. No more harmonious couple could be found anywhere. They are united by the bonds of mutual affection and respect. And still though married for a number of years they have lived a continent life. Mr. A's sexuality is extremely weak and rudimentary, while Mrs. A's is distinctly negative. That is she has a *dislike* for sexual relations of any kind. They became aware of their feelings in this respect within the first weeks of their married life and they decided to live like loving friends. Though they generally share the same bed they do not attempt any sexual relations. And while they are both impotent they are both free from any neurasthenic symptoms, are contented and good, hard workers.

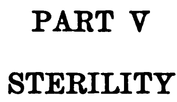
Case 4. Mrs. B. Thirty years old. Confesses to having masturbated for many years; she does not remember exactly how many, but probably eight or ten. Married one year. Has a fairly strong libido, but finds that the orgasm occurs immediately upon the husband's attempt at sexual relations, and then she feels tired (and disgusted) and either permits no relations, or does so with gnashing teeth. In short she suffers with precipitate ejaculations exactly the same as impotent men do, and is therefore to be classed as an impotent. She knows that she is impotent — she has read a good many books on the subject —

but she does not mind it, is very active and cheerful and is free from any trace of neurasthenia.

Case 5. Mr. C. Age 58. Is completely impotent, having neither desire, nor power of erection. Has been so for the last five years. He tells me that since his "menopause"—he shared the prevalent error that the menopause in women marks the cessation of all sexual desire — he has been in better health, possessing more calm, more equanimity, than ever before, that he is turning out better work than he did ten or twenty years ago and that he feels perfectly satisfied. If his sexual power could be restored to him without any trouble, he thinks that he would not care to have it restored. [He came to consult me not for his impotence, but for frequency of urination which I found was due to some prostatic hypertrophy.]

I could report several more cases, presenting strong conclusive or corroborative evidence that impotence does not necessarily drag neurasthenia, or melancholia, or any other neurosis or psychosis in its wake. But such reports would become wearisome by their sameness. But I consider it necessary to emphasize and reemphasize that a man suffering with sexual impotence may be in perfect health otherwise: physical, mental and psychic. This emphasis is necessary in view of the great confusion that exists in the medical and lay mind on the subject, and in view of the great needless suffering which impotent men have been undergoing, as a result of this confusion.

And I therefore consider the above one of the most useful and valuable chapters in the book.



PART V

STERILITY

CHAPTER THIRTY-SIX

GENERAL CONSIDERATIONS

In former years sterility or the inability to procreate children was considered one of the greatest of calamities; it was a disgrace and a humiliation. Up to very recently the woman was the only one that was held up to blame in cases of sterility. Nobody even thought, much less suggested, that the man could ever be to blame in the matter. And the poor wife, who might be perfectly normal sexually, dragged herself from doctor to doctor, and was subjected to all kinds of treatment for a trouble which she did not have. Now we know better. We know now that in a large percentage of cases it is the man that is to blame exclusively for the absence of children in the home, as we will see later in pointing out the causes of sterility in man and woman.

Whether we should rejoice over it or deplore it, it is a fact that sterility is no longer the terrible, disgraceful calamity that it was considered years ago, say only thirty or forty years ago. Many people take their sterility quite philosophically. We know several couples who have been married for many years and have no children, and they do not seem to mind it in the least. They live quite happily, and they never consult a physician about the matter, apparently being satisfied with their fate.

But the parental instinct is not yet — and of course never will be — quite extinct, and to many couples the

greatest, the only, tragedy of their lives is the fact that they have no children. We have had both the rich and well to do, the poor and very poor to plead with us with tears in their eyes to do something for them, to give them a child. I will say in parantheses that among the rich it is generally the husband and among the poor it is the wife, who is the most anxious for progeny. And what greater happiness than for a couple that has been barren for five, ten or fifteen years to be suddenly blest with a child, an heir, a descendant! The praises of the doctor who has been responsible for this miracle will never cease to be sung. And it is important that any physician dealing with sexual abnormalities — and cases of sterility often occur in the practice of the general practitioner — should have a good idea of the causes of sterility and of the treatment of curable cases.

We will consider sterility in the male and in the female separately.

CHAPTER THIRTY-SEVEN

CAUSES OF STERILITY IN MAN

An absolute impotentia coeundi will naturally also result in impotentia generandi. Any condition, which will render intercourse *impossible* of accomplishment, will also be a cause of male sterility. As such conditions we may mention congenital absence of penis, extremely diminutive size, extreme hypospadias and epispadias (by either rendering erection and intromission impossible, or by causing the discharge extra vaginam), tremendous scrotal hernias or hydroceles, total lack of erections, whatever the cause may be — mechanical, paralytic or psychic. All the conditions just enumerated may be the cause of a man's failure to impregnate his wife, and still we object to designating a man suffering with any of the above troubles as sterile; because, if his semen be only normal, then by a little skill, a little manipulation, or, if need be by the use of certain little appliances, impregnation may be brought about. In other words the above described conditions are only accidental or temporary and not essential and permanent causes of sterility. And it is only of these essential causes that we wish to speak here.

Real male sterility consists in the *absence of semen,* (ASPERMIA or ASPERMATISM), or in the *absence of spermatozoids* in the semen (AZOOSPERMIA.) As the testicles are the principal organs which generate the semen and

the only organs which generate the spermatozoa,* absence of the testicles will result in aspermatism and in azoospermia. This absence of the testicles may be congenital, or they may be present but undescended, hidden in the abdominal cavity (cryptorchidism), or they may be removed by operation (castration), or destroyed or rendered pathologic by disease (syphilis, gonorrhea, tuberculosis, great pressure from hydrocele). If the testicles have been completely removed and destroyed, then there are of course no spermatozoids at all; where the testicles are present but diseased, then we may have only a few spermatozoids, a condition to which we apply the term Oligozoospermia; or the spermatozoids may be non-motile, "dead," a condition to which we apply the term Necrozoospermia.

This condition of Necrozoospermia may be due not only to the condition of the testicles, but often depends upon the pathologic condition of the prostate and the seminal vesicles. The spermatozoa in the unmixed testicular fluid are non-motile; they begin to move or swim about only when the testicular fluid is mixed with the secretion of the seminal vesicles and of the prostate, and it is the latter secretion (prostatic) that seems to be essential to the motility of the spermatozoids. A diminished acidity or positive alkalinity of the prostatic secretion or a catarrhal or purulent prostatitis or vesiculitis may cause necrozoospermia and sterility.

For some cases of azoospermia, oligo- and necrozoospermia no cause can be found. The testicles, the prostate and the seminal vesicles are apparently normal in every re-

* I use the terms spermatozoids, spermatozoa and zoosperms indiscriminately.

spect; there is no history of any trauma, venereal disease or other infection, there is perfect libido and potentia coeundi, and still the semen shows abnormalities — there are either no spermatozoids at all, or they are very few in number or they are " dead."

This abnormality is undoubtedly of congenital origin (and nothing can be done for it).

We have spoken until now of sterility due to abnormalities in the semen or rather spermatozoids. But there are cases in which the semen is normal, but the man is nevertheless sterile, because *he can not bring his semen out.* It is manufactured in the testicles all right, but on the way from the testicles to the meatus there is an obstruction which prevents its further passage. And it thus becomes as useless as if it were not there. The most common condition we have to deal with is obstruction of the epididymides and of the vasa deferentia, due to bilateral gonorrheal epididymitis. Just as gonorrhea is one of the greatest factors in causing impotentia coeundi, or ordinary impotence, so it is the greatest cause in causing impotentia generandi or sterility, and we may well say that gonorrhea is the greatest enemy to procreation, the greatest obstacle to the multiplication of the human race. We may say that in male sterility gonorrhea is a more important factor than all other causes combined; probably seven or eight cases out of every ten are due to this cause — gonorrheal epididymitis (and prostatitis). Another cause which may cause complete aspermia is a tight stricture: the semen cannot pass the barrier and goes back into the bladder. Just as we have retro-pollutions, so we can have retro-ejaculations. Not only an organic stric-

ture, but a spasmodic stricture, spastic contraction of the urethral sphincter at the moment of ejaculation, may have the same effect—the regurgitation of the semen into the bladder.

It may be somewhat surprising to some, why a stricture that is not small enough to cause retention of urine (if it were it would be operated upon) should cause an obstacle to the passage of the semen; why if it is permeable to the one it should not be permeable to the other. But the conditions are not the same; the urine is a thin liquid propelled forward by the powerful contraction of the vesical sphincter; the semen is a thick viscid, sometimes almost gelatinous semi-fluid and is propelled forward only by the weak contraction of the muscular fibres of the bulbus urethrae. No wonder that on meeting an obstruction, it goes back into the path of least resistance.

And besides, in the condition of erection the urethral lumen becomes still more obstructed, and a narrow lumen may become completely obliterated. We know that it is very difficult to urinate when the penis is erect; it is easy to understand why in the above described conditions the discharge of the semen externally becomes impossible.

Other causes of obstructive aspermia are obliteration of the ejaculatory ducts from ulcerative inflammation of the urethra or prostate, abscess of the prostate, prostatic hypertrophy, new growths, tuberculosis, prostatectomy, congenital absence of the ejaculatory ducts and congenital or acquired deviation of the openings of the ejaculatory ducts.

A symptom often complained of by those suffering with obstructive aspermia or ejaculation into the bladder is a

colicky pain in the urethra and neck of the bladder, and a heavy dragging sensation in the testicles. Where the vasa deferentia are obstructed, so that the semen cannot leave the testicles, the latter often swell up, become congested during coitus and cause an unpleasant heavy sensation for several hours to come.

Another curious form of aspermia, of which I have seen many cases, remains to be considered, a form in which the genital glands work normally, in which even the semen is normal, in which there is no obstruction to the egress of the semen, and in which nevertheless no ejaculation takes place in spite of the most ardent and most strenuous coitus. Those men will sometimes foolishly continue coitus for fully half an hour or an hour, until they feel completely exhausted, and still without any trace of ejaculation.

I have been able to distinguish two varieties of this form of aspermia. In one variety there is a history of extreme excess, either excessive masturbation or excessive intercourse. I would call this variety exhaustion aspermia. A man may go on indulging for several weeks or several months in incredible sexual excesses. One day perhaps he will perform the act more often than usual, ten or fifteen times in the twenty-four hours. To stimulate himself he will take a lot of alcohol in various forms, and all at once during one coitus he will feel that he has no ejaculation; he will attempt again and again with the same result. The spinal ejaculatory center has been exhausted, paralyzed, and no more semen will be discharged perhaps for months, perhaps for years to come. Just as the erection center may be exhausted, so that the man will be unable to get up an erection, so the ejaculatory center

may be exhausted. Both centers may become exhausted simultaneously, but as the centers are separate and independent, so each center may become exhausted independently of the other. While as a rule, the erection center is the one that is more readily exhausted and "paralyzed," there are cases where the reverse takes place: the ejaculatory center is paralyzed, while the erection center remains unimpaired.

Most cases of exhaustion aspermia recover under rest and appropriate treatment, though in some cases it may take as long as three, four or five years before the normal or even more or less normal condition is established.

In the other variety of aspermia there is no history of excess or exhaustion of any kind. And here we have two subvarieties. In one subvariety the patient tells us that he never had an ejaculation in his life, neither in normal intercourse, nor as a result of erotic dreams. The patient is well in every respect, his libido is normal, his erections are normal, he indulges in licit or illicit intercourse regularly and still — never an ejaculation. That we have to do here with a functional and not with an organic aspermia, that it is not a case of non-formation, but merely of non-ejaculation of semen, is seen from the fact that on massaging the testicles, milking the vesicles and expressing the prostate we can express a fluid which has all the characteristics of semen and contains spermatozoa, though perhaps few and not very lively ones. This is a congenital abnormality. The ejaculation center is absent or what amounts to the same thing is non-responsive to any ordinary stimuli, and that is all there is to it. I would call this subvariety *congenital functional aspermatism.*

In the other subvariety the patient tells us a different story. He has been normal for years, but gradually the ejaculation was becoming retarded, until it ceased altogether. If we examine the history we may find a variety of different factors. Either he practiced coitus interruptus with his wife; or he had relations with an unmarried woman where the possibility of impregnation stood before him as a ghostly specter, or he hesitatingly confesses that his wife has lost all attraction for him, and it is against his will that he has relations with her. At other times a patient will tell us that he is unable to have an ejaculation with his wife only, while he is normal with other women; other men will complain just the other way: they can have normal relation with their wives, but can have no ejaculation with other women, or when they are the first time with other women. Some have no ejaculation only under certain conditions, in certain positions, etc. In short we have to deal here with *acquired psychic aspermatism,* and cases of this character are all amenable to treatment.

A cause of sterility that is of rather recent origin is Roentgen-ray azoospermia. Particularly in the first years of the discovery of the x-rays, before their power and by-effects were well understood, many people who worked with the rays unprotected became temporarily sterile. Experiments in irradiating the testicles and ovaries of animals have shown that direct exposure to the rays destroyed the spermatozoa and ova, stopped their production and rendered the animals sterile. The sterility however was only temporary and neither the libido nor the erectile power were affected, showing again conclusively, if further proof was needed, that libido sexualis and potentia eri-

gendi were not dependent upon the generation of spermatozoids and could exist without the latter.

Radium can produce the same results as the Roentgen rays.

Other causes of sterility may be simply mentioned without discussing them in detail, because they are not absolute, only relative causes of sterility. They are: excessive obesity, diabetes, homosexual tendencies and *inbreeding*. Communities and families that marry only among themselves, without letting in any fresh blood, become relatively sterile. Aristocratic families, who intermarry only among themselves, generally die out within one hundred to two hundred years. An idle, luxurious life is considered by some as conducive to sterility. But in my opinion if it does do so, it does it not directly but indirectly. An idle, luxurious life is conducive to sterility, because it is conducive to sexual excesses and venereal diseases; and these of course lead to both impotence and sterility.

Intense intellectual work however is directly conducive to sterility, as it is conducive to impotence, or at least to relative sexual weakness. Strong intellectual work has a decided depressing effect on the sexual function, and for this reason we find that the really great writers, thinkers, scientists, philosophers and mathematicians rarely have many children. This is due to three causes: diminished libido, diminished potency and relative sterility. Their descendants are few; their families do not persist long; they are soon extinguished. How many descendants of the really great thinkers and writers are now alive?

CHAPTER THIRTY-EIGHT

THE TREATMENT OF MALE STERILITY

Whether due to good luck, that is to pure coincidence, or really to good judgment, the fact is that the author has been exceptionally successful with his cases of male sterility. Some cases of barrenness are not due to sterility at all. They are due to ignorance, to awkwardness. If we find the man's sperma perfectly normal, and find nothing in the woman to account for her failure to conceive, then a confidential talk is in order, and sometimes a word or two of advice sets everything right. (I am sorry that I cannot speak more plainly.) If we find a catarrhal prostatitis, the prostate must be massaged and other means employed until the condition is removed. Seminal vesiculitis must be treated in the same manner. Inflammation around the ejaculatory ducts must be relieved by sounds and silver nitrate instillations. A stricture should be dilated or cut. Epispadias and hypospadias of extreme degree must be surgically corrected.

The most frequent cause of sterility however, as we have seen before, will be found in a former gonorrheal epididymitis, unilateral and still more so bilateral. Can we do anything for these hard nodular epididymides? I believe we can. I never make any definite promises, not even half-promises. But I have had so many successes from massaging the testicles with various ointments, that I cannot admit they were all due to accident, or coincidence. If a

man, who has had a double gonorrheal epididymitis, has remained sterile for three or five years and then after three to six months' treatment comes and tells you in high glee that his wife is in "the family way," then you are justified in assuming that that impregnation is not merely a sequence, but a consequence of your treatment. And if an unpleasant cynic should remark that a wife's pregnancy is no absolute proof that the impregnation was from the husband, we would tell him that of some wives you can be sure. There are some wives who would be no more capable of committing adultery than they would be of committing murder — or of flying in the air without the aid of an aeroplane. But we need not depend upon the faithfulness of the wife. If a man comes to you and you find that his "semen" contains no spermatozoa, or only a few dead remnants, and after six months' or a year's treatment his semen is full of lively motile spermatozoa, then you have your scientific proof, and you have a right to believe that your treatment did it.

Treatment of Old Epididymitis. My treatment of old gonorrheal epididymitis consists briefly in hot baths and in massage of the testicles with various "absorbent" or "resolvent" ointments. I usually begin with two ointments, one a five to ten per cent. unguentum hydrargyri, the other one unguentum potassii iodidi, full or half strength. I order pulling down each testicle (with epididymis), making scrotal skin over it as tense as possible, and rubbing the ointment over it, gently but firmly for about ten minutes, before going to bed. Where the patient can conveniently do it, he is to do the massage twice or even three times a day. One night the mercurial ointment is to be used, the

next night the ointment of potassium iodide. Besides the massage, either one of the ointments (I change off) is to be smeared over the entire scrotum, the latter covered with non-absorbent cotton and oiled silk and the whole enclosed in a well fitting suspensory bandage or jack-strap. This may be worn the greater part of the day and the whole night. The scrotum is to be washed every morning with soap and hot water. Every fourth, third, or in people with very sensitive skins, even every other day all treatment is to be suspended, the scrotum washed with soap and water and covered with talcum powder. Instead of talcum powder I sometimes order an ointment of zinc oxide and bismuth subnitrate (for exact formulas see Section on Prescriptions). If the precaution of leaving off treatment every now and then and applying emollient ointments and powders is not observed, the skin of the scrotum will soon get very sore and full of pimples, so that treatment will have to be suspended for a long time.

The baths are preferably sitz baths, and should be taken as hot as can be borne and in the evening before going to bed. The patient should stay in the bath for about ten minutes, dry himself, massage in the ointment, taking about ten minutes for the operation, cover the scrotum with a little extra ointment, apply the cotton or oiled silk, put on the suspensory bandage and go to bed. After a hot bath, any ointment is much more readily absorbed.

Do not prescribe Ung. Hydrargyri and Ung. Potass. Iod. in the same ointment, for gradually there is formed some red mercuric iodide, which is very irritating.

Instead of potassium iodide I sometimes prescribe an ointment of lead iodide, which seems to work very nicely.

I also prescribe potassium iodide internally in doses of five grains three times daily. Whether it does any good or not, I don't know. But as it is supposed to have a resolvent action on swelling and nodules, there is full justification for giving the patient the benefit of the doubt.

After a month or two of such treatment the hardening in the epididymis will in many cases be found to soften and disappear, and spermatozoa may appear in the semen.

AN INTERESTING CASE.

To show what can be accomplished in apparently hopeless cases by the above simple treatment I will reproduce here a case which I reported in the New York Medical Journal under the title A Unique Case of Artificially Induced Sterility. The case is as follows:

Mr. L. B. 32 years old. Married 3 years. The wife is very anxious to have a child and they have been to a number of physicians but to no avail. Libido present in a high degree and potentia coeundi while not very powerful is satisfactory. Denies ever having had venereal disease. Confesses to masturbation when a boy but in a moderate degree only. Examination of the expressed prostatic fluid shows it to be normal. The fluid expressed by stripping the seminal vesicles shows complete absence of spermatozoa. Examination of the ejaculate obtained by normal intercourse in a condom shows what appears to be macroscopically normal semen. The microscopic examination again shows the complete absence of spermatozoa. The urine is perfectly clear and normal chemically and microscopically. No trace of shreds. The examination of the testicles however shows a peculiar state of affairs. There are a

number of hard spots and nodules throughout. The globus major of the right epididymis shows an almost stony hardness.

I accused him of concealing the truth. I told him that he must have had a gonorrhea or some other inflammation or some kind of traumatic injury. I told him that it was no use denying it, for something he must have had there, otherwise the testicles and their epididymis would not present such a condition. He then told me the following story. He said he had never told it to any physician because some how or other he felt ashamed. But as I insisted that he must have had something the matter with him and as I was a "professor" he would tell it to me.

He was born in Russia, at the age of twenty-one he was drafted into the army. As the treatment of the common soldiers in the Russian Army is exceedingly coarse and brutal many young men fear the service as much as people here fear hard labor in the penitentiary and try to escape it by all possible means. They undergo various mutilations so as to be declared unfit for military service. In spite of the fact that when the willful mutilations are discovered they are punished severely, those unhappy young men prefer to take their chances. Anything only to avoid the Russian military service. Some have cataracts produced on their eyes, some have the thumb of the right hand amputated so that they cannot pull the trigger. Some have their hip joint dislocated, others have immense scrotal hernias produced, or immense hydroceles. Still others take cardiac depressants for a long time so that when the time comes for examination for military service their heart is

very weak and rapid, etc., etc. What this young man had done to him was the following:

He had a slit made in the scrotum, a foreign body of the exact shape of the testicle was introduced, there was injected some irritating stuff so as to produce some inflammatory adhesions. The idea was to make the medical examiners believe that the man had an abnormally large and inflamed scrotum, that he had three testicles instead of two and thus was unfit for long marches and would be declared unfit for military service. Whether infection from the outside took place or whether the injection was too irritating, both the scrotum and the testicles swelled up enormously — he says they were ten times their normal size, which is perhaps some exaggeration — and he was in great agony for a long time. As ill luck would have it the medical examiners recognized the deliberate nature of the injury and he was taken to the hospital where he stayed five or six months before he got well. The foreign body was, of course, removed. After he got out of the hospital he was sent to a Disciplinary Battalion where the treatment is much more brutal of course than in ordinary battalions.

This is as far as I reported the case in the New York Medical Journal. I concluded the article with the following paragraph:

"Whether my efforts to restore the permeability of the epididymides and the vasa deferentia will prove successful remains to be seen. I shall report the treatment and the results of it later on. In the meantime I thought the case worth recording merely for its etiology."

I can now report upon the results. He was treated exactly as outlined above, and after three months' treatment,

spermatozoa, quite lively motile spermatozoa, though very few in number, appeared in his prostatic and vesicular expressate! His wife is not pregnant yet, but there is no reason why she should not become so in the near future.

Operative Treatment

If this treatment has been kept up for several months without the desired results, that is, the semen still remains free from spermatozoa, then the operation first proposed by Edward Martin may be performed. Dr. Martin thus describes the operation:

"I demonstrated in dogs that after cutting the vas a short distance from its origin in the epididymis and forming an anastomosis of this divided vas end with the head of the epididymis, subsequent ejaculations of the dog would be found to contain a normal number of motile and apparently healthy spermatozoa. Some animals, under observation for months, apparently showed that there was no tendency toward closure of this artificial opening.

A morphological study of the human spermatozoid taken from the rete testis, the upper part of the epididymis, and the vas seemed to show that these spermatozoa underwent a developmental change in their progress through the epididymis, suggesting that even though this method of anastomosis might be applicable to men sterile because of obliteration of the epididymis it did not necessarily follow that the spermatozoa thus short-circuited would be fertile.

The method of proving whether or not such spermatozoids would be fertile lay in a clinical application of the

knowledge gained by experimental research; therefore we operated on a man whose childless marriage apparently was absolutely dependent upon azoospermatism consequent upon a double obliterating epididymitis. He was most anxious for children, as was also his wife. She had been subjected to dilatation and curettement before it was discovered that her husband was sterile. In the fall of 1897 he suffered from gleet, having had two attacks of acute urethritis, one twelve years and one four years before. Both attacks were severe. The first was complicated by rheumatism, the second by bilateral epididymitis. There was a large stricture in the bulbous urethra, with ulceration behind it. There was also some follicular prostatitis. Gradual dilatation, irrigation, and massage cured the gleet. In the spring of 1898 it was discovered that the semen contained no spermatozoa. There was no nodulation of the tails of the epididymes. The right testis was the larger of the two. The patient was directed to wear a sweating suspensory bandage, and was ordered testicular massage. A prolonged course of internal medication supposed to be helpful in causing the absorption of inflammatory fibroid material proved unavailing. Repeated examinations failed to show the presence of spermatozoids until March, 1901, when, on careful search, two or three ill-formed ones were found in each cover-glass preparation. In the fall of 1901 a most thorough search failed to show the presence of a single spermatozoid. . . .

The patient was etherized on the evening of December 24th. The vas of the left side was freed at about the

level of the top of the testis, and, by means of a sharp-pointed pair of scissors, a slender bistoury, and a grooved director, such as are used by opthalmologists, its lumen was opened by a longitudinal cut a quarter of an inch long. The epididymis was then approached from the outer side and its entire length was exposed. An incision into the tail failed to show the presence of a milky fluid, though cover-glass preparations subsequently examined demonstrated a few spermatozoids in the expressed fluid. A portion of the head was then picked up in a toothed forceps and excised. A few minute, whitish drops at once appeared on the resulting cut surface, made up in the main of spermatozoids, some of which, when examined fifteen minutes later, were motile. Into the wound of the epididymis the vas was implanted by means of fine silver wire carried on small face needles from the outer surface of the vas into its lumen, then from the cut surface of the opening made into the epididymis through its fibrous tunic. A suture was placed at either end of the vas incision, and the latter was held open by two other sutures, one on either side. The skin was closed by catgut. The dressing slipped the next day, exposing the wound, which became infected and suppurated superficially. Semen twelve hours old sent for examination January 11th showed the presence of spermatozoids not so plentiful as usual, but very actively motile.

On January 9th this patient resumed marital relations, and on October 17, two hundred and eighty-one days later, his wife was delivered of a normal girl baby, exhibiting an almost ludicrous resemblance to her father.

This completes the demonstration as to the value of an anastomosis between the vas and the epididymis in case of sterility due to obliteration lesions in the tail of the epididymis, apparently proving that even though certain formative changes do occur in the spermatozoids during their course through the epididymis, these changes are not crippling in so far as the procreative power of the spermatozoa is concerned."

In a personal communication dated February 11, 1913, Dr. Martin tells me that he has performed the operation between thirty and forty times, and while he can never "bet" on the outcome, the result is usually good.

In congenital aspermatism we "of course" can do nothing. But as we cannot always be absolutely positive as to whether the aspermatism is congenital or acquired, there is no reason why we should not give the patient the benefit of the doubt, especially as the treatment is in no way injurious, and may do the general sexual condition good, even if it does not help to generate spermatozoa. I had several cases in whom two or three successive examinations failed to show any spermatozoa. I gave the patients an absolutely unfavorable prognosis. Still they insisted that I try. I tried. And lo, in several months, their semen showed the presence of spermatozoa and their wives became pregnant. I therefore no longer refuse, except when the testicles are completely lacking, to treat cases of aspermatism, of whatever origin.

The treatment of aspermatism consists in frequent hot baths, in massaging the testicles with "warming" or counterirritant ointments (see Section on Prescriptions), in a rich diet, consisting of eggs, meat, fish, oysters, etc., in the

administration of general hematinics and tonics if they are indicated and in *directing* the patient's thoughts and life toward sexual subjects. This treatment will give us satisfactory results in a gratifyingly large number of cases.

CHAPTER THIRTY-NINE

STERILITY IN WOMAN

For a woman to be fertile, i. e., to be able to conceive and to bring forth a living child into the world, four principal conditions are essential: the external genitals must be present and normal so as to permit of normal intercourse; she must produce normal ova; the way between the ova and the spermatozoa must not be obstructed, so that the two can meet; the uterus must be normal, so that the impregnated ovum, when implanted in the uterus, finds a suitable soil for its development, and does not die or is cast off prematurely before it can live an independent life. And it is here where woman's greater responsibility and therefore greater importance to the race reside. When a man has discharged his spermatozoa his work is done: woman's only commences. Man's share in the perpetuation of the race is insignificant as compared with woman's. While for practical purposes the spermatozoa are of equal importance with the ova, both being necessary for fertilization, for the production of an embryo, from a biological point of view they are not. For we have been able recently to fertilize the eggs of some lower forms of life without the intervention of any male element; we cannot produce a living being from a spermatozoon, without an ovum.

To express it concisely: To do his share in the perpetuation of the race, a man must possess potentia coeundi

and potentia generandi; a woman must besides these two also possess potentia gestandi. There is one point in which woman has the advantage over man: impotentia coeundi which plays such a great rôle in man's sexual life, causing sterility, physical ill-health and psychic misery, seldom plays any rôle in woman.

Causes of Sterility in the Female

The conditions in the female which render intercourse difficult or impossible and are thus a relative or an absolute cause of sterility are: a tough, leathery hymen, a very narrow vagina, vaginismus and atresia or complete absence of the vagina.

A tough, impenetrable hymen is more often a cause of sterility than is imagined. While some hymens are so fragile that they tear at the first attempt, however slight and gentle, others offer great resistance, and there are cases where women have been married for years with the hymen intact. This is particularly the case, if the husband's erectile power is not very great. Some hymens are very elastic, they undergo a great deal of gradual stretching, the couple is under the impression that they are having regular intercourse, while in reality the wife remains a virgin. I know of one case, where they indulged in intercourse for eight years, and while they indulged in intercourse frequently, the wife remained childless. The husband was sexually rather weak, and on examination the wife showed a thick, tough hymen, perfectly intact. The hymen was slit open and impregnation quickly followed. Intercourse apparently always took place in the *fourchette*.

A very narrow vagina can be an occasional cause of sterility, on account of the semen being deposited in the anterior portion and not reaching the cervix. But the condition being recognized is readily remedied, by stretching, use of a neutral lubricant, etc.

Vaginismus may be a very effective barrier against impregnation, for in true vaginismus the pain at the mere attempt at intercourse is so intense, and the spasmodic contraction so powerful, that no intromission is possible. Unless treated and alleviated or cured, the consequences of any attempt at intercourse are so profound and disagreeable, that the husband gives up in disgust or resignation, and seeks satisfaction elsewhere or sues for divorce.

Atresia vaginae if complete may be as effective a barrier against impregnation as absence of the vagina. One would think that absence of the vagina would not have to be considered at all among the causes of sterility, because a girl in whom the vagina was missing would not think of getting married. This is far from being the case. Strange and incredible as it may seem, some girls with this serious defect are not aware that there is something radically wrong with them. So ignorant are many of our girls on the subject of sex. They may know that they are not like other girls because they do not menstruate, but they have heard that some girls begin to menstruate very late, and they truly think that marriage will make everything all right. Others *know* that they are abnormal, and these act in one of two ways. Either they tell their prospective husbands nothing, being anxious to get married at all hazards, and take their chances of

remaining with their husband or getting divorced from him (for legally the husband has an unquestioned right to divorce); or they make a clean breast of the matter (their mothers generally do), and give the man the choice of taking or leaving them. One would think that a man would never marry a girl whom he knew to be deficient in one of the most important attributes of woman. But he who would think so would show that he did not know everything. The motives, feelings and springs of action of men and women are difficult to fathom.

The following is an experience in my own practice.

Miss L., an intelligent, attractive and well-developed woman of twenty-four. I had known her for sometime, because I was treating her mother. One time she came to my office, and after some hesitation, told me she thought that there must be something wrong with her, as she never menstruated in her life. She did not feel any illness on account of it, and therefore she never cared to have herself examined or treated. But now she had a good chance. A very nice and well-to-do man wanted to marry her, and she wanted to know if she was fit to marry. An examination showed complete absence of vagina, not a trace of anything corresponding to the vaginal canal. Rectoabdominal examination also showed absence of uterus. I told her the true state of affairs, and of course never thought that she would think of marrying. But I soon heard that the marriage was to take place. The mother informed the man of her daughter's condition, and he was willing to take her as she was. And it is to be borne in mind that he did not marry her for money, for

she didn't have any. It was he who had the money. I had my misgivings about the union, but things seemed to be satisfactory. I saw them now and then for about two years after they were married, and they seemed to live harmoniously. After that I lost track of them.

A gonorrheal or profuse leucorrheal discharge is apt to render the woman sterile.

Conditions in the uterus itself apt to lead to sterility are: Anteflexion and anteversion, retroflexion and retroversion, cervicitis, the plugging of the os uteri with tough mucus (a frequent condition), traumatic stricture of the os uteri, due to lacerations in child birth, or caustic applications, etc., endometritis, metritis, fibroid tumors, fibromyomata, etc.

The condition in the Fallopian tubes most frequently leading to sterility is salpingitis, which is in the vast majority of cases of gonorrheal origin. Here we meet again with the gonococcus as the greatest factor in race suicide. Both in men and women it is the greatest factor in the causation of sterility.

Ovarian disease (if bilateral) is of course apt to cause sterility. Not however necessarily so, for a very small portion of healthy ovarian tissue is sufficient to generate ova for the purposes of impregnation. There are cases on record even where the ovaries had been removed by operation, and still the woman conceived. Evidently a small portion of the ovary was overlooked and remained behind.

The ovaries may be histologically healthy, and the ova may be diseased. They may become diseased from infection with diseased spermatozoa (syphilis), or the con-

stitutional disease in the woman may be the cause (syphilis, malaria, pernicious anemia).

Very severe constitutional disease may result in the stopping of both menstruation and ovulation, and be thus the cause of sterility, which however is generally temporary.

CHAPTER FORTY

TREATMENT OF STERILITY IN THE FEMALE

Removal of the Cause. The treatment of sterility in the female will suggest itself in most cases. We must find out the cause, and wherever possible remove it. A tough hymen should be incised. A very narrow vagina may be gradually stretched, and the use of a very small amount of mild non-antiseptic lubricant (chondrus jelly, a few drops of sweet oil) suggested. Vaginismus should be treated according to the suggestions outlined in the chapter on vaginismus. The cervical plug should be removed, gonorrhea and leucorrhea should be cured, and malposition of the uterus should be corrected, tumors should be removed, a diseased uterine mucous membrane should be curetted, pus tubes should be drained, general constitutional diseases should be energetically treated according to well known principles (syphilis with mercury, salvarsan and iodides, malaria with quinine, anemia with iron and arsenic, etc.).

Sometimes merely an advice as to the proper position or change of position *in coitus* is all that is necessary to bring about an impregnation in cases which were barren before for years.

Artificial Impregnation. Suppose we have a case, in which the husband's semen is found normal, and we can find no pathologic lesions; or if there were lesions, they have been corrected. What are we to do then? In such

cases we assume that for some unexplainable reason the spermatozoa cannot reach the os uteri, or that the vaginal secretion has the property of killing the spermatozoa or making them inactive. In such cases we are perfectly justified in attempting artificial impregnation.

The technic while very simple requires great skill and care. The fresh semen is drawn directly from the condom into a sterilized syringe with a long nozzle, warmed up to about 99° F. The cervix is drawn down and a small quantity (a few drops) of the semen is injected into the uterus. The rest of the semen is put on a tampon of cotton which is pushed up against the cervix. The woman remains in bed several hours. No douches or antiseptic applications are to be made. It is important to inject only a few drops, as a large quantity of semen may cause uterine colic, inflammation and perhaps even extrauterine pregnancy.

The question, if impregnation with the semen of a strange man, provided both husband and wife agree, is ever permissible, is a ticklish one and is answered differently by different physicians. It is a well known fact that the wives of sterile husbands are sometimes so fearfully anxious to become mothers, that their husbands agree to their artificial impregnation by the semen of another man. Prof. Fürbringer states that he had in his practice many such cases. He knows the case of a sterile physician, who himself injected semen from another man into the uterus of his wife. Prof. Strassmann employed the method three times but only once successfully, but in this case the value of artificial impregnation was proven beyond a doubt. It was the woman's second marriage.

Her first marriage was also childless. He injected 1 Gm. of semen; the woman had no intercourse thereafter and she became pregnant. Afterwards she had two more children without artificial aid.

Dr. Joseph Hirsch of Berlin recently reported that he tried the method in 16 cases, in 6 of which it proved successful, i.e., the women who had been sterile for many years, became pregnant. He thinks that if he had been perfect master of the technic from the beginning his results would have been better still, because all the first seven cases were failures, the six successes being among the nine last ones.

The method of artificial impregnation has now been used successfully in a sufficient number of cases to make its use justifiable in all cases of female sterility, in which other measures have proved unavailing.

It is a curious fact that the first reported case of artificial impregnation is by a clerical man. In 1767 the Abbott Spalanzani reported the successful artificial impregnation of two bitches. In 1790 John Hunter reported a successful case of artificial impregnation, the husband being afflicted with hypospadias.

CHAPTER FORTY-ONE

SEPARATELY FERTILE, BUT MUTUALLY STERILE

An interesting question which we are sometimes asked is this: Can it happen that a man who is fertile and a woman who is fertile will when coming together remain sterile? It can. Mr. A may be perfectly potent and normal and Mrs. B may be perfectly potent and normal, and still they may live together for years and be incapable of having a child. And A will marry C and B will marry D and both couples will have children. How do we explain this phenomenon? We explain it this way. The mere coming together of a spermatozoid and an ovum will not fertilize the ovum. It is necessary that there should be a chemical attraction between the two: chemotaxis. The reason spermatozoa of one species of animals will not fertilize the ova of another species is because chemotaxis between the two is lacking. We assume then that the reason a perfectly fertile man with normal motile spermatozoids will fail to impregnate a perfectly healthy woman with perfectly normal ova is because there is no chemotaxis between the male and the female elements; there is no attraction, or perhaps there is even an actual repulsion. In other words we would say that the given spermatozoa and ova are incompatible, while the man's spermatozoa may be perfectly compatible with or exert chemotaxis for the ova of another woman, and her ova for the spermatozoa of another man.

In real life such cases are not very rare. Mr. and Mrs. Smith have lived together for ten or fifteen years without issue, without a single impregnation. They divorce and Mr. Smith marries Miss or Mrs. Jones while Mrs. Smith marries Mr. Robert, and in a short time both families have children in the house.

Experiments on animals have also shown the possibility of such a condition. A male animal, known to be fertile is paired with a female known to be fertile; and though they are brought together during several breeding periods, the union remains sterile. A change of the male or the female results in impregnation. Such experiments have been performed frequently, have been reported by Darwin forty-five years ago and are known to every breeder.

The question, Can sterility be due to lack of love or mutual attraction? I must answer decidedly in the negative. Impregnation depends exclusively upon physical and chemical conditions, and where these are suitable, impregnation will result (sometimes rather unfortunately), no matter if the husband dislikes his wife or the wife hates her husband. The spermatozoa and ova do not care for the feelings of their owners. Even in cases of brutal rape, where the victim is horrified at and loathes the rapist with every fiber of her soul, impregnation takes place.

PART VI

SEXUAL DISORDERS IN WOMEN

CHAPTER FORTY-TWO

DIFFERENCE BETWEEN THE SEXES

As a rule we do not speak of women as being sexually impotent; though in a sense they may be, still they are not so in the sense that men are. A man to be potent must possess the power of erection, and his ejaculations must not be too premature; a woman has no erection center, and she may be utterly devoid of libido, she may suffer either with precipitate orgasm or she may be unable to experience the orgasm at all, she may even have a loathing for sexual intercourse, and still she can participate satisfactorily — that is satisfactorily to the man — in the act. There is therefore a fairly valid reason for not speaking of sexual impotence in the female. Barring local conditions in the vulva and vagina, we speak of women as frigid and barren or sterile.

Frigidity in Women

We apply the term frigid to women who have little or no sexual desire, or who are incapable of experiencing any voluptuous sensation during the act. The two, i.e., lack of libido and inability to experience the orgasm, may and often do go together, but not necessarily so. That is, a woman may have very little sexual desire, and still be able to enjoy intercourse when she does have it; and on the other hand, she may have a strong sexual desire and be utterly incapable of experiencing any orgasm.

Is frigidity in women frequent? Yes, quite frequent.

very much more frequent than the same condition is in men. I am aware of the fact that some medical writers and some radicals are trying to make us believe that there is practically no difference between the manifestations of the sexual instinct in man and in woman. I decidedly disagree with this view and I claim, (1), that lack of libido or frigidity is present in a much larger proportion of women than of men; (2), that the sexual instinct awakens in women much later than it does in men; (3), that the libido sexualis is much less developed and plays a lesser rôle in women than it does in men and (4), that continence in women, for not too long periods, is much more feasible than it is for men.

I know full well that there are girls and women as passionate as any man can be — and more so; I know that in some girls the instinct awakens very, very early and occupies their entire life; but these are exceptional cases, and do not militate against my general statement. I admit also that women are very fond of the company of the opposite sex, and feel the need of being loved, petted, fondled and caressed even more than men do, but this feeling differs to quite a degree from the "gross" act of sexual intercourse. This is not the place to go into a detailed discussion of the differences in the sex instinct in the male and female, but these two facts may be brought to the reader's attention. There are any number of girls who go on to the age of 18, 20 and 25 without as much as a sexual stir. No purely sexual longings, no night emissions, no masturbation. They live as calmly up to that age as if there were no sexual instinct. And such girls are perfectly normal. When they get married they manifest a sex instinct, healthy

in every respect. We find no such instances among normal young men. The instances of young men who had no sex manifestations up to the age of 18 or 20 are exceedingly rare, and when found they are instances of young men of very weak or abnormal sexuality; young men who will never be any good sexually. Another fact well known to any sexologist is the following: There are many married women who for the first few years of their married life have very little sexual desire and experience very little or no pleasure in the act. It takes them several years of experience and "education" before they "wake up." There are no men who require several years of sexual education before their instinct is awakened. The normal boy's instinct needs no education and no guidance. These two facts point out sufficiently that there is quite a difference of degree, if not of kind, between the sex manifestations in the two sexes.

Frigidity in Women is of Different Degrees. Leaving out of consideration the women who *loathe* intercourse, or the embrace or even the mere approach of a man, and who are probably in most cases homosexual, there are many cases that have absolutely no desire and no pleasure. They do not loathe the man, they may even respect and love their husband, but with the best will they can not get up any sexual desire. A man is to them an indifferent object. The sexual act is devoid of any pleasure to them, and no matter how frequently repeated they fail to experience any orgasm or even any pleasurable sensation. Some of these cases are congenital and unamenable to treatment. Others are suffering only from retarded development, that is for some unexplainable reason, the ovaries, clitoris, etc., are in

an infantile condition, and the woman reaches her full sexual development only at the age of 25, 28 or 30 or even later.

Aside from these cases of complete frigidity there are milder cases, where the woman has merely a weak sexuality, and needs sexual satisfaction only once in two, three or four months. Others are indifferent; they can indulge frequently and enjoy the act fairly well or in a fashion, but they can also go without any indulgence for years, without feeling any the worse for it. To some women — with a perverted education, or rather a perverted sense of propriety, the act appears as a nuisance. They like the preliminaries of the act, they experience some orgasm, but they do not like the *modus operandi*.

We must bear in mind however that a very large percentage of frigid women are frigid only because their husbands are awkward and ignorant. Very often a little instruction to the husband converts an allegedly frigid sexless wife into a very normal, even passionate wife. And it happens that a wife who passed for frigid with one husband is complained of by the second husband as passionate and even too exacting. Frigidity may also arise from dislike of or hatred of a certain man. A woman may involuntarily freeze sexually at the attempted touch of one man and melt away at the approach of another. I am speaking here of the purely physical act. I know the case of one woman who never could experience an orgasm with her husband, but was very passionate with other men. (We meet such cases in men too.) Such cases we might designate as psychic or pseudo frigidity.

The Treatment of Frigidity.

The treatment of frigidity is more a matter of common sense and skilled judgment than anything else. No rules can be laid down, and unfortunately the discussion of the subject cannot be as free as we might want it to be. For in spite of the fact that this is a medical treatise intended for medical men, we are not allowed to speak with perfect freedom, to use perfectly plain and explicit language. We have a real censorship in this country which often makes one write haltingly and hesitatingly, where the clearest language is necessary.

For instance I know a number of cases of frigidity which by a certain treatment were brought to a normal condition. One woman became very passionate, her health improved wonderfully, her whole outlook upon life became changed, and she has not words enough to thank her physician. And still should I venture to describe the method here in all its details, this book might be declared unmailable by our sage censors, who are ready to sacrifice human happiness to their perverted standards of morality.

I can therefore give but a few hints. For the congenitally frigid woman very little can be done. The treatment will also be much more efficient in women of the well-to-do classes who can afford leisure, luxuries, travel, amusement, the best kind of food, etc., than in women of the poor classes, who have to do hard work, can afford no extravagances, and have no romance in their lives. Very often in cases of female frigidity the person to be instructed or treated is not the woman, *but the man.*

The diet should be rich and generous, with a large per-

centage of proteids. Eggs (preferably raw), meats, fish, oysters, caviar, should be consumed liberally, with plenty of condiments. Wine, particularly champagne, is useful, and should be taken with the dinner or a late supper. Hot baths, occasionally with a little mustard, before going to bed are decidedly efficacious. A warming stimulatory ointment to the external genitals (clitoris and introitus vaginae) often does good service, though it is possible that a part of its efficacy depends upon the element of suggestion. (But what difference does it make, as long as it works?) Medicinally, the drugs that I have found useful are thyroid preparations, lecithin, strychnine and such aromatic and stimulating drugs as capsicum, ginger, cardamom, saffron and cinnamon. In the last part of the book a number of prescriptions will be found presenting the most eligible forms for administration.

Case Reports of Frigidity.

Case 1. Mrs. X. Has been married three years, loves her husband (so she claims and he corroborates it), loves to be with him, but fails utterly to experience any sensation during intercourse. Not merely no pleasurable sensation, but no sensation whatever. Examination shows the vaginal mucosa abnormally dry and rough and clitoris very small. Frequent mustard sitz baths, with application of warming ointments and certain manual manipulations brought about considerable improvement, and six months later the husband reported that she was "about as good as other women."

Case 2. Mrs. Y. Married seven years. In this entire period experienced no desire and no sensation whatever.

As she says, her husband is "just the same to her as a wooden Indian." She indulges frequently because the husband demands it, but the act gives her no pleasure whatever and no suffering either. It is a matter of perfect indifference to her. She has given birth to one child. They never use any preventives.

Case 3. Mrs. Z. Married four years. Begs to help her, because the sexual act causes her great suffering. Not exactly pain, but a sensation which she cannot describe. She has to shut her mouth tight and use great will power not to cry out, for she is trying to do everything not to have her husband suspect the true state of affairs. She is afraid in case he should find out how painful the act is to her he would cease to love her and would perhaps go to other women. She was a very sweet timid creature, and she said that she was willing to undergo any kind of treatment only to get well and to be able to satisfy her husband.

Case 4. Miss I. Twenty-four years old. Absolutely no desire of any kind, no menstruation at all. Examination shows total absence of clitoris, vagina, uterus and ovaries. Externally she is normal in every way, and looks pleasing and attractive. Of course I had to tell her that in her case there was nothing to be hoped for.

THE MENTAL ELEMENT IN THE CURE OF FRIGIDITY.

Case 5. The following case very well illustrates what an important rôle the mental element plays in frigidity and in the cure of frigidity. He was a dry goods merchant from a small town in a mid-western state. She had been a school teacher. They loved each other, but she was absolutely frigid. They had been married seven years,

and during the entire period she never had any desire or experienced any real orgasm. She submitted to his embraces but remained quite passive. They led a quiet, monotonous humdrum life. Whenever he would go on his buying trips, she would be left home alone. He consulted a local doctor about her frigidity, who said he knew nothing about such things, and one doctor in New York, but he couldn't suggest anything, especially without seeing her. Once when he had to go to New York to buy goods, he decided to take her along. First to give her a little vacation (he recollected after seven years!) and perhaps to have her examined by a specialist. The specialist found nothing abnormal generally or locally and made general suggestions, about diet, more recreation, more interest in life. The following evening the representative of the house from whom the husband bought most of the goods took them out to show them the town. He took them first to a musical comedy show — the naughtiest and most risqué thing they had ever seen (one of the Anna Held shows), then they went for supper to one of the "swell" Broadway restaurants, where she saw a life she never saw before, and after that they went the rounds of a number of places, like the Haymarket, Black Cat, Cairo, where the provincial young woman saw things that she never even dreamed of before. In each place they also took a drink or two. That night, the husband told me, was the first time that she ever exhibited passion, and she experienced a strong orgasm. And from that time on she has been normal, nay, above normal.

This story has a sequel. It is the husband who is now coming for treatment. After five years of a very active

and mutually satisfactory sexual life, he finds that his power is getting weaker while her demands are getting stronger. And he finds it impossible to satisfy her, which makes her very irritable and unhappy. His libido is diminished and his ejaculations are premature, and now he regrets exceedingly that night in the New York Tenderloin. If she had not been aroused, while her sexual pleasures would not have been so great, he would not have to suffer what he has to suffer now. Some men take their inability to satisfy their wives very tragically.

CHAPTER FORTY-THREE

VAGINISMUS

The term vaginismus, originally introduced by Marion Sims, has been used rather loosely to designate any condition of painful coitus. This is not correct and leads to confusion. The term vaginismus should be limited to a condition of acute hyperesthesia of the vaginal entrance or of the entire vaginal canal of such a degree that the mere touch of the finger or of the male member induces a violent spasm of the vagina, rendering intercourse absolutely impossible. If the penis is introduced with brutal violence, then the woman may faint and remain unconscious. The patients have a horrible dread of either an examination or of intercourse. As Sims describes such a patient: "She is like a timid nervous person who has once had a pointed instrument thrust into the exposed pulp of an inflamed nerve in a decayed tooth."

It is stated that vaginismus may occur in a woman after she has had normal sexual relations for some time, as the result of some disease like vaginitis. I have never come across such a case, and don't believe in the possibility of its occurrence. If a vaginismus-like condition occurs as the result of some inflammatory condition of the vagina or vulva, then it is not true vaginismus, and the cure of the inflammation removes the pseudo-vaginismus. Vaginismus is an affection *sui generis* and makes itself manifest at the first attempt at intercourse. I believe however that

a brutal first night, with an inconsiderate and ignorant, or a loathed husband may be the exciting cause of a vaginismus.

The pathology of vaginismus is varied. In some cases we find absolutely nothing on the most careful examination. Everything is normal, the hymen is not thickened, there is no irritation or redness, in short there is nothing to account for the extreme hyperesthesia and violent spasmodic contractions. These are really the only cases of pure vaginismus. In other cases we find inflammation of the vaginal entrance and of the vulva. We may find a fissure in the upper portion, or ulcers or caruncles near the urethra, or there may be an ulcer on the cervix, etc.

Treatment.

The first condition of proper treatment is complete sexual rest. To attempt intercourse over and over again, as is so often done, in the hope that it will finally come out all right is both foolish and cruel. The condition is only aggravated. The patient should have perfect rest and should be sure that no attempts will be made on her. The mere fear of the possibility of an attempt is injurious and can put the patient all a-tremble. The treatment consists in thorough cocainizing, eucainizing or alypinizing the vaginal outlets, beginning with the opening of the hymen and proceeding gradually inward. After the local anesthesia is complete we use dilators made of hard rubber or metal in gradually increasing sizes. After this treatment has lasted for some time, we may advise intercourse, but under the following conditions: A pledget of cotton soaked in a 10 per cent. solution of cocaine is ap-

plied to the vaginal inlet for a few minutes; then a suppository containing 3 grains of cocaine or 5 grains of eucaine or alypin is introduced into the vagina and allowed to melt, which takes about five minutes; and then the male member anointed with a warm lubricant is introduced. The bromides are generally useless.

In the cases of moderate severity this treatment is generally sufficient. In extreme cases the hymen or the carunculae myrtiformes have often to be excised, and the sphincter vaginae has to be incised or stretched and torn with the fingers, under general anesthesia of course. Sims' method may be followed; it consists in putting the woman under a general anesthetic and then having the husband perform intercourse with her. Either after this procedure or when the sphincter is torn or incised some after-treatment is generally necessary. The after-treatment consists in anesthetizing and in cauterizing the parts.

It goes without saying that any pathologic condition, such as fissures, ulcers, caruncles, inflammations, found accompanying the vaginismus must be treated vigorously. The best treatment consists in anesthetizing the lesions and then cauterizing them with a ten per cent. silver nitrate solution. Or a copper sulphate stick may be used. After this cauterization a powder like aristol or airol with or without orthoform is applied liberally.

There are rare cases — I have had one such case — where the intercourse is but moderately painful, but the contraction of the sphincter vaginae takes place during the act and the male member is held captive for several minutes. In this case I advised intercourse with the aid of a

lubricant which contained a local anesthetic. It worked very well.

CASE OF PSEUDO-VAGINISMUS.

Mrs. M. Twenty-four years old. Married two years, and has had gonorrhea two years, for she was apparently infected the very first night. She had no treatment for the first two months, and then for several months while being treated she did not know what was the matter with her because the husband asked the physicians not to tell her. Her case got gradually worse, until, when she consulted me, I found a well developed salpingitis on the left side. She became run down, anemic and has constant dragging pains and occasional sharp pains in the side. The interest of this case lies in the fact that for the last eight months she developed a violent vaginismus, which made intercourse absolutely impossible. At any attempt on the part of her husband, who is not any too refined, she would have a violent contraction, which would make intromission as impossible as if she suffered with atresia vaginae. And the attempt causes her atrocious pain. And still I do not consider this a case of true, but of pseudo-vaginismus. And for the following reasons. First, she confessed to a strong dislike of her husband, who ruined her life and rapidly converted her from a bloomingly healthy girl into a chronic anemic invalid. Second, the introduction of a finger, a speculum, a tampon, or any manipulation in the vagina, causes *no pain* and *no contraction*. The vagina and vulva present no signs of irritation. I am strongly of the impression that with another man she would have no symptoms of vaginismus. This is therefore a case, as I stated, of pseudo or psychic vaginismus.

CHAPTER FORTY-FOUR

ADHERENT CLITORIS OR PHIMOSIS IN THE FEMALE

A narrowness, constriction or elongation of the prepuce, or an adhesion between it and the glans penis rendering the exposure of the latter difficult or impossible is termed phimosis. The clitoris being an analogous organ to the penis, there is no reason why the term phimosis should not also be applied to an adhesion between the prepuce and the clitoris. This condition, when marked, is apt to give rise to symptoms much more pronounced than are caused by phimosis in the male. An adherent prepuce is apt to be the cause of smegma and concretions, which in their turn cause irritation, which may and often does lead to masturbation. The masturbation increases the irritation, and thus a vicious circle is established which reacts upon the general system. The more important results of adherent clitoris, however, are the effects produced on the sexual functions. In many cases the woman's libido is perverted, or she is unable to experience the proper orgasm and the act leaves her in a state of excitement and irritation, which forces her to resort to masturbation, no matter how disgusted she may feel with the pernicious habit. In some cases adherent clitoris may give rise to a violent vaginismus.

The treatment of adherent clitoris or phimosis consists in separating the adhesions, either under local or general

anesthesia. Sometimes it is necessary to circumcise the prepuce. Either of these operations is generally followed by marked relief, though it may take a long time before the symptoms caused by the phimosis, which symptoms may have assumed the character of a habit, disappear entirely.

REPORT OF CASES.

Miss A., 19 years of age. Suffers with severe cardiac palpitation, coming on at irregular intervals. During the interval the heart action is normal. Black rings about the eyes, very anemic, lack of appetite, but the worst complaint is insomnia. It yields to hypnotics but the doctor prescribes them unwillingly and she herself is afraid of them. Confesses to masturbation, but begs to be given something to be cured of the habit, as it affords her no pleasure, on the contrary it leaves her very weak and depressed; but she cannot help it. Examination discloses a large but bound down clitoris, and some abrasions about it and on the labia. Separation of the adhesions under cocaine anesthesia, cauterizing with 20 per cent silver nitrate solution, the application of a menthol-phenol ointment to the external genitals, general tonic treatment with glycerophosphates and organic iron preparations and warm douches at night brought about a complete cure.

The following two cases were reported by Dr. Mary E. Bates in a very good paper on "Phimosis In the Female," which appeared originally in the *Woman's Medical Journal* and was reprinted in *The Critic and Guide* for November, 1906.

The first case is that of a woman of 25. She had menstruated first at 17 and had married at 21. Had always

had dysmenorrhea, and backache, which had formerly appeared only once in a while, but was now practically constant. Occipital headaches were frequent, also pain in the left inguinal region. When six months married she left her husband for a six months visit and dreaded to return. Claims to love him and to want children. Has not been pregnant. Has never experienced *libido sexualis*. Intercourse occurs once in a month or two. Patient is very anemic, frail and unhappy looking. Yet she looked more like a girl of 17 than a married woman of 25. A man with her expression would be marked for a sexual neurasthenic at once. She exhibited some morbid tendencies, being inclined to suspect everybody of sex irregularities, immoralities, etc. She herself was suspected of malingering and had at one time received some benefit (not enduring) from a practitioner of suggestive therapeutics. Until the cocaine found a foothold, the separation of the clitoris was exceedingly painful and excited uncontrollable trembling of the lower extremities which did not cease for half an hour. The clitoris was larger than normal, which is often the case, especially when the concretions are large. This patient had a marked vaginismus. She could not tell whether penetration had been complete or not. Her husband says it had not been. Before the parts were quite healed a very great improvement in tone, color and "nervousness" was noticed. The patient lost her look of abject forlornness and had spells of actual liveliness and well-being within three weeks after the clitoris was freed.

The second case is that of an unmarried woman 33 years of age. Has been "nervous" ever since she can remember. With the development of puberty she became con-

scious of herself sexually. Krafft-Ebing says that sexual desire during the years of maturity is a physiologic law, and she was conscious of obedience to the law. As a child she had irritable bladder and enuresis. Several times a year, depending on circumstances, she has had nocturnal emissions. At many other times she has been awakened by peculiar sensations that she came to recognize as the same in kind that in the dream state preceded the orgasms. She has always had very high ideals, and has succeeded in keeping free from voluntary self-pollution. She has been much worried about her condition and has been somewhat morbid at times when under stress. She has loved, or thought she did, several times, and is anxious for a home and family. She is afraid of herself and of men, especially those for whom she feels attraction, and this fear makes her avoid them and even seem "queer." She has had treatment for dysmenorrhea. One physician gave her intra-uterine galvanism. She had an antipathy for this man and experienced a decided vaginismus at each sitting and stopped the treatments. There was no libido with the vaginismus.

This patient has had some curious reflexes, for instance an intense hypersensitiveness to odors. She always has nasal catarrh just before menstruation. Her clitoris was strongly adherent and there were some concretions. The parts were very sensitive. During the days occupied in the healing process while the irritation was considerable, she had a sensation of being tied down, bent over as a bow is by the string, her shoulders pulled forward. She has always had the same feeling whenever she had a secretion from sexual desire. During the post-operative days she

had pain in the pharynx, under the ears, and at the base of the brain all round except in the back of the base. This disappeared as she got well. She thinks, as she analyzes it herself, that she always had the adhesions, but that it made no trouble until she rode a wheel. The seat as constructed made pressure on the clitoris. This irritation increased her sexual desires. She used to sing — an expression of well-being. For years she had not, and had wondered if she ever would sing again. Since the clitoris is free she sings again. She suddenly found herself singing with perfect spontaneity, as she had sung years before. The irritability of the bladder also returned to considerable degree, and disappeared as the wound healed. The night after the separation of the hood, she had a distinct contraction, a muscular spasm of the muscle of the inguinal regions, and felt a forcible expulsion of fluid at the vaginal orifice. This was different from the experience during orgasm. She felt the fluid as far as the clitoris and examining found it to be as she felt it. She has acquired a different attitude and is no longer at extreme tension. Her nervousness subsided gradually. How much of her nervousness will abate and how far she can recover, time alone can tell.

While the present author would not ascribe the same importance as does Dr. Bates to adherent clitoris as an etiologic factor in sexual disorders of the female, being certain that some of the cases described by her could be explained on a different basis (lack of sexual satisfaction), he nevertheless considers it a frequent enough and important enough condition to receive more attention from the medical profession than it has received heretofore. As

a cause of masturbation, adherent clitoris is well established, and in little — or big — girls who show a tendency to handle the genitals the clitoris should be carefully examined for adhesions, smegma, concretions and ulcerations, and any pathologic condition remedied.

CHAPTER FORTY-FIVE

INJURIES TO THE FEMALE IN COITUS

Injuries in coitus to the female genitals are more frequent than to the male genitals, and more frequent than is generally known, because only a small proportion of the accidents, when for instance the hemorrhage is very profuse, comes to the notice of the physician. The accidents arise generally from the brutal impetuousness, awkwardness or *ignorance* of the man.

As a rule the rupture of the hymen is followed by a trifling hemorrhage. The tear, however, may extend into the vaginal wall, and then the hemorrhage may be alarming. There is one case on record where a girl died from the hemorrhage caused by the rupture of the hymen on her wedding night, and there are several hundred cases in medical literature where surgical aid had to be called in to stop the hemorrhage. The cases of Neugebauer and Frankel abstracted by Taylor are respectively as follows:

"A woman had a severe hemorrhage from the genitals on her wedding night. She was an undeveloped girl of sixteen, anemic and rachitic. There was a history of two attempts at coitus, the second of which was attended by great pain and followed by bleeding, which would not yield to hemostatic measures. The author found evidences of profuse hemorrhage, with a hematoma of the right labium majus. The hymen had not been ruptured, and the left labium majus was intact. There was a laceration of the

right labium majus 4 cm. long, while the corresponding labium minus was edematous and bluish-red in color. There was constant oozing from the wound. Introduction of the finger showed a false passage filled with clots. The penis had made an artificial route for itself in the paravaginal tissue. A tamponade failed to produce hemostasis, and it became necessary to lay open the bleeding area and ligate."

Frankel reports a case in which he was consulted by a bride of three days for hemorrhage from the genitals incidental to first successful coitus. External genitals were intact, save for a tear in the hymen extending to the base. Vagina ample in size. Sagittal tear was found close to junction of uterus with vagina in lateral fornix. Husband's penis was normal in size. The early attempts at coitus had failed, the husband being unable to penetrate the vagina. During the third night the wife awoke with intense sexual desire, and sat astride of her husband, he being at the time in a high degree of excitement. The penis penetrated at a single impulse, and great pain and hemorrhage followed, although the coitus was completed. Within a quarter hour the gravity of the hemorrhage was realized and the surgeon was consulted. Active hemorrhage had ceased, but the vagina was distended with clots. From the ragged and deep character of the wound in the fornix the writer assumed that coitus took place within it, including ejaculation. Both the wound and vagina were tamponed. Healing occurred without complications or sequelæ.

In a case of mine the bleeding caused on the wedding night lasted for two months. The husband insisted on nightly intercourse and would not give the wound a chance

to heal. When I saw the case I found quite an ulcerated surface, from which oozed a purulent sanious fluid, and extremely painful. It was the pain at intercourse, which she could stand no longer, that brought her to me. Cauterization with a 20 per cent silver nitrate solution, and abstinence for a week brought the condition to normal.

But it isn't only during the first night or first week that injury is apt to result. There are cases of women who had been practicing intercourse for months or years, who were dangerously injured during coitus. This is apt to be the case when there is a great disproportion between the size of the vagina and the penis, and when the man is in a state of excitement, perhaps somewhat under the influence of liquor.

Treatment. The treatment of injuries in coitus is surgical; mild lacerations should be irrigated with warm antiseptic solutions and the vagina packed with antiseptic gauze. More serious wounds are to be sutured, vessels ligated, etc. The ordinary rupture of the hymen needs no treatment, but applying a pledget of cotton soaked in peroxide of hydrogen or in chinosol solution will prevent soreness and suppuration, which occasionally takes place.

But the treatment of traumata in coitu should be prophylactic; injuries *should not* take place. The man should be instructed to be gentle and not too impetuous the first night. If intromission is accompanied with severe pain, if there seems to be a real obstruction or a spasm, he should desist, and try again another night. The use of a lubricant is perfectly proper and will both facilitate the introduction of the member and save the bride a good deal of pain.

Where the hymen is tough and leathery and penetration is difficult and painful, it is better to have the hymen incised or stretched by a physician than to have it ruptured by brute force. For in the latter case, not considering the pain and the danger of hemorrhage and suppuration, the woman may get a loathing of the sexual relation or she may begin to suffer with pseudo-vaginismus. The incision made by the surgeon is always cleaner and heals quicker than the rupture made by a brutal husband.

PART VII

PRIAPISM

CHAPTER FORTY-SIX

DEFINITION AND VARIETIES

The term priapism is often applied incorrectly. In my opinion the term priapism should be applied only to cases of prolonged obstinate erection, unaccompanied by sexual desire and unrelieved by intercourse. Where the priapism is of short duration and due to some acute local inflammation we apply to it the term chordee. The term satyriasis is often confused with priapism, but this is a gross error, as the two are entirely different things. The first, satyriasis, implies insatiable sexual desire, and may or may not be accompanied with erection. In fact satyriasis may exist with complete impotence, with complete inability to have an erection. There are a few cases of priapism in which sexual desire is present, and priapism may coexist with satyriasis, but the essential feature is that in priapism the erection does not subside after intercourse; in fact no ejaculation takes place as a rule and the condition is often worse after than before the act.

The extreme cases of priapism, lasting uninterruptedly for days, weeks and even months, come rarely to the notice of the physician, even of the sexual specialist, but cases of moderate severity are not infrequent. A not uncommon type is the following. The patient tells you that for the last few weeks or months he has been waking up in the middle of the night, about 3 or 4 in the morning, with a strong erection. It annoyed him and he got up

thinking that if he passed urine the erection would subside. But he found great difficulty in urinating; there seemed to be a great obstruction to the egress of the urine (as there is in every erection) and the strongly erect position of the penis made the act of urinating very uncomfortable; he had to bend over, until he was on all fours. After he finally did succeed in urinating, in a dribbling manner, he found that the erection was not in the least affected thereby. He then thought that intercourse would relieve him. He had no desire but he wanted to get rid of the annoying erection. The intercourse was very unsatisfactory, and it took an inordinately long time before he succeeded in having an ejaculation. He felt exhausted. Some patients do not succeed in having any ejaculations, no matter how long they continue the act. But in either case, whether an ejaculation takes place or not, the erection has not been in the least affected for the better. If anything it has become worse. Towards morning the erection gradually subsides.

CHAPTER FORTY-SEVEN

ETIOLOGY OF PRIAPISM

When we examine such cases we may find a granular patch in the posterior urethra, or a painful local inflammation in the prostate, or a seminal vesiculitis. Very often, we can find no cause whatever, and we then say that the priapism is of central nervous origin. Priapism due to changes in the blood is a well known variety. A particularly well known cause is leukemia. Why leukemia should cause priapism is not known, but the fact is as well established as any in medicine. Following the classification of Blum, we may give the causes of priapism as follows:

I. Priapism from local causes in the erectile tissues:

(*a*) of an inflammatory nature (gonorrhea, suppuration, thrombosis).

(*b*) of a neoplastic nature (carcinoma, sarcoma, gumma).

(*c*) of a traumatic nature (mechanical injury, causing hematoma)

(*d*) resulting from circulatory disorders (thrombosis, hemorrhage)

II. Priapism from *nervous* causes:

(a) in organic diseases (of the brain, spinal cord, injuries of the vertebræ)

(*b*) in functional diseases of the brain and spinal cord. (Without any discoverable lesion)

III. Priapism in constitutional diseases:
(a) intoxications (cantharides)
(b) infectious diseases (very rare)
(c) constitutional diseases and diseases of the blood, (leukemia)

Priapism in the preataxic stage of locomotor ataxia is well known. Its symptomatology is thus described by Peyer.

"This priapism appears mostly at night when the inhibitory center for erection is put out of function by sleep. According to the severity of the case the patient awakes at two or three o'clock in the morning with a violent and indeed often painful erection, which produces absolutely no voluptuous sensations or sexual ideas. After he has lain awake some time the erection disappears, but when he has slept again for several hours, he is again awakened by the same phenomenon. If the cases are more severe, the erection does not disappear on awaking, but the man must get out of bed, apply cold compresses, and walk about for hours in his room until the priapism finally leaves him. In some few cases a water-clear, viscid secretion flows continuously from the urethra, coming from Cowper's glands (urethrorrhea ex libidine). In the worst cases the priapism appears after only an hour of sleep, and is accompanied by severe neuralgic pains in various parts of the body, such as the calves, the knuckles, soles, arms, etc. Impotence is not rarely associated with this form of priapism, especially when the latter has arisen through masturbation. And when the patient attempts coitus, with the physician's advice, the erection fails completely, only to appear again later in a tormenting way when he is alone."

CHAPTER FORTY-EIGHT

REPORT OF CASES, WITH POINTS ON THE TREATMENT

The following three cases, one from my own practice, one reported by Blum, and one by Billaud will serve to illustrate the varieties of priapism and the differences in the treatments.

Case 1. Physician 48 years old, well and strongly built, active and attends to a large practice. Masturbation between the ages of 14 and 18, had rather frequent though irregular sexual relations between 18 and 27, at which age he married. Has three fine children. The first ten years or so of married life practiced coitus interruptus, occasionally also coitus reservatus. But during the last ten years the relations were normal and about once a week. For the last five years he has noticed a gradual diminution in his libido. About two years ago he began to wake at about 5 A. M. with strong lasting erections without any libidinous desires however. Physician though he is he did not recognize their true character. He was rather pleased at their appearance, and he thought that they indicated a return to his former potency. He had frequent relations, but found that intercourse did not subdue the erections. He would often have intercourse two or three times in one morning. Gradually the erections began to make their appearance and wake him earlier and earlier — 4 A. M., 3 A. M. and when he came to consult me, they used to wake him at about 2 A. M. or even earlier. He tried cold com-

presses, hot compresses, but with little relief. His sleep was thus greatly interfered with, and he was quite emaciated when I saw him. Internally he took potassium bromide in 15 grain doses, three times a day, but without any benefit.

On examination I found the entire urethral canal hypersensitive, the posterior urethra exquisitely so. In the prostate there were scattered three or four very tender spots. The seminal vesicles were normal. An examination of the blood showed a rather poor hemoglobin content, but nothing to indicate leukemia.

My treatment was as follows: I learned long ago, that in diseases of long duration, besides the disease proper we have also to count with the vicious habit that has been established. We must break the habit first of all, if we can. We must overhaul the system. I am not what our friends the quacks term a drug-doper, and I treat hundreds and hundreds of cases without a single dose of medicine. But I have no superstitious fear of drugs, and when I do give them I give them to effect. I gave him the bromides of potassium, sodium and strontium in doses of 20 grains each together with 10 grains of chloral, to be taken immediately before going to bed; I also ordered suppositories of 5 grains of antipyrin and 1-3 grain of morphine, one to be inserted on going to bed. In addition to this I ordered a very hot bath in the evening. This may seem strange to some, and it did seem strange to my patient. But in such and similar cases hot baths are the proper thing; cold baths are apt to prove injurious and to aggravate the trouble. He did as I told him and he slept through the night undisturbed. The second night I told him to leave out

the bromides and to use the suppository only. He slept through the night, but there was just the suspicion of an erection. The third, fourth, fifth and sixth nights he used the hot baths, and both the bromides and the suppositories, and was entirely free from any erections. In the meantime I treated his urethra with silver nitrate instillations and the psychrophore, and the prostate by massage. The second week he used the bromides and the suppositories alternately, one night the former, the second night the latter. The third week he found he could get along with the suppositories alone, first used every night, then every other night. From the fifth week he found an occasional dose of the bromides or of the suppositories was sufficient to keep down the erections entirely. He soon gave up the use of all medicine, and for over six weeks he was free from any manifestations of priapism. Then he began to have the erections again, but they came on towards morning and were not so recalcitrant. A few doses of the bromides and of the suppositories relieved him permanently. It is now six months since he gave up the use of any medicine, and he has had no priapistic erections. But he also notices that his normal erections, caused by libido and an attempt at intercourse, are quite weak. This is something which I foresaw might happen, and warned him of the possibility of its happening. But when the choice is between priapism and loss of erections we must choose the latter. The patient's general health however has improved markedly, and he feels quite satisfied with the results.

Case 2. The second case, reported by Blum, is that of a boy of twenty. It is a case of leukemic priapism.

The patient does not remember ever to have been seriously ill. Has suffered from frequent nosebleeds since his 16th year. Other hemorrhages did not occur. Family history shows no blood diseases. He denies that he was ever given to masturbation, and does not remember ever having had pollutions. But he had erections often at night. Has had regular sexual intercourse since his 15th year. Has never suffered a venereal infection. Six months ago he fell from a ladder upon his perineum and suffered a crushing of the right testicle, which led to a traumatic epididymitis, that healed completely after six weeks.

About a week before entering the hospital he awoke with a violent erection, which still persisted after micturition. He tried to go to his work, but could hardly move on account of violent, drawing pains in the testicles, and hence went to bed. Local treatment with ice and hot compresses was of no use. The penis had been continually in a state of erection for a week and during this entire time he had no sexual desire and no pollutions.

An examination of the patient showed a strikingly pale, weakly patient; visible mucous membranes anemic; slender build, no pains in the bones, no edema, no cyanosis; abdomen somewhat distended. Entire left side taken up by a tumor, which extends beyond the middle line with a conical process the size of a goose-egg and down to the hip-bone; it feels smooth and dense to the touch, and from its form, consistency and position can be diagnosed as a splenic tumor. Its largest dimensions are twenty-eight cm. long by twenty-four cm. (11x9½ inch) wide. Numerous lymphatic glands in size from a pea to a hazelnut may be felt in the groin and axilla and also in the right supraclavicular

space. The penis is in extreme erection, and is 21 cm. ($8\frac{1}{2}$ inch) long; it feels as hard as bone. It is evident on nearer examination that the erection is limited to the corpora cavernosa, the blunt ends of which may be felt through the quite flaccid glans, which is half covered by a normal prepuce. The corpus spongiosum is flaccid and soft. The penis lies nearly on the middle line of the body; the glans almost reaches the navel. On rectal examination one could feel the ends of the corpora cavernosa erected, hard and firm; the prostate normal.

The urine contains traces of proteid and in the sediment uric acid crystals of whetstone and barrel shapes in great abundance and numerous squamous epithelia and leucocytes.

The blood examination showed a proportion of leucocytes to erythrocytes of 1 to 5 (565,000 white and 3,235,000 red corpuscles). The blood was typical of myelogenous leukemia.

The priapism remained unchanged in spite of all local measures, ice and baths, and Roentgen ray treatment given for thirty-two days. On that day the corpora cavernosa felt softer, and one could clearly make out fluctuation in one place in the middle of the penis. A diagnostic puncture was made and about half a centimeter of bloody fluid was aspirated. This showed under the microscope a plasma extremely poor in fibrin and numerous red corpuscles in advanced stages of degeneration, also remains of leucocytes and numerous granules. The whole preparation was interspersed with countless strongly refracting crystals of various lengths (on the average about five erythrocytes in diameter).

After this the erection gradually diminished, only the root of the penis still showed induration for a long time. The patient could finally leave the hospital after the erection had lasted in all nine weeks. The Roentgen-ray treatment, which consisted in irradiation of both the spleen and bones as well as the penis, had no essential effect upon either the erection or the blood. The splenic tumor, however, diminished about a third in size.

Case 3. The third case was reported by Billaud (Provence medicale, March 23, 1912).

The patient was a farm servant aged 26, who had been married a month. There were no pathologic antecedents, although the man was of a nervous temperament. Up to the time of entry into hospital the state of priapism had lasted for seventeen days. The condition had commenced suddenly without apparent reason, and the turgescence and rigidity extended to the corpus spongiosum as well as the corpora cavernosa. No medical treatment had been of any value. Cold and hot applications and compresses, leeches to the root of the penis and applied to the lumbar region, were equally unavailing. Bromides, morphine, and chloral had only the effect of making him drowsy. They had no local action. Sexual intercourse was out of the question, as introitus became impossible owing to the size and wooden hardness of the organ. Masturbation resulted only in making the continuous pain more severe. The weight of his clothes, the least movement, became insupportable. He passed urine normally and without pain, and this indeed was his sole relief. An anesthetic having been administered and a gum-elastic catheter placed in the urethra, two parallel incisions — each corresponding

to a corpus cavernosum — were made. A quantity of black viscid blood immediately escaped, and the organ subsided. The next day, after a good night, the patient suffered no further pain. There was still some edema, however, and hot fomentations were applied. The wound practically healed by first intention, and a few days later was only slightly swollen. The patient left the hospital after twenty days, and up to the time of leaving had had no erection; the author is unable to say whether or when he had any erections afterwards.

THE TWO MODES OF ONSET.

It will be noticed that the last two cases differ materially from the first. In the first, the priapism was chronic and intermittent; the onset was gradual, and there were periods of complete freedom from erections; in the last two cases, the onset was sudden, acute and the priapism lasted without intermission.

Summary of Treatment. To summarize the treatment of priapism: Where a local condition can be found — inflammation in the urethra or prostate — it is to be treated. As a general sedative: hot baths, bromides and chloral in large doses internally, and morphine (with or without atropine, with or without antipyrin) in the form of rectal suppositories. Where leukemia is present, Roentgen rays to the spleen, and blood preparations internally. Benzol, which has been reported favorably in cases of severe leukemia from Koranyi's Clinic, may be tried. In some cases incisions into the corpora cavernosa is the only promising procedure.

PART VIII

MISCELLANEOUS TOPICS

CHAPTER FORTY-NINE

IS MASTURBATION A VICE?

We are in the habit of referring to masturbation as a vice. I would not like to be misunderstood on this point. I consider masturbation a vice only in the sense that any habit which injures the individual, making him less useful to himself, to society, or the race, is a vice. It is no more a vice than is excessive sexual intercourse, marital or extra-marital, or excessive eating is. It is less of a vice than alcoholism is. It is the excess feature in it that constitutes the vice.

Used by adults in moderation there is nothing vicious and nothing degrading about it. We know of a number of adults who, for reasons which need not be entered into here, do not wish or are unable to have normal sexual relations. They practice the habit with more or less regularity and in moderation, the same as they would normal coitus. They do not become slaves to the habit and a moderate indulgence in it does not seem to hurt them. There is no reason for stigmatizing such people as vicious or degraded. They may be the gentlest, finest, and noblest specimens of manhood.

It may be objected that this question, whether or not masturbation is a vice, is out of place in a book which presumes to deal with the practical treatment of sexual disorders; but it is not, for in my opinion our way of looking at certain habits has a distinctly practical aspect. In my

opinion stigmatizing even the most moderate indulgence in masturbation as a vice, has a deleterious effect on the people who so indulge, and makes it harder for them to break off the habit. Every thinking physician and every thinking parent can tell you that picturing the masturbatory habit in too lurid colors and stigmatizing it with too strong epithets, has as a rule the contrary effect to the one expected. The victims of the habit consider themselves degraded, irretrievably lost. They lose their self-respect and it is on account of that harder for them to break themselves of the habit.

We must look at the matter from a common-sense, sensible point of view. We will accomplish a good deal more with our youthful and older patients, if we leave alone altogether the moral side of the question, if there be any moral side to it, and emphasize the physical injuriousness of the habit. We do not want to diminish the self-respect of our boys and girls, we want to increase it; and we cannot do it if we make them believe that a masturbator is a vicious criminal. Inspire your patients with confidence, tell them that indulgence in the habit jeopardizes their future growth, physical and mental, health and happiness, and you will find it easier to handle them.

In conclusion, fairness demands that I state that some investigators not only refuse to look at masturbation as a vice, but consider it a useful hygienic measure, a safe, harmless substitute for coitus. They claim that we confuse cause and effect. That many of the bad symptoms which we ascribe to masturbation become apparent only when an attempt is made to break the habit, or after it has been given up entirely. And some physicians (Dr. Stekel

of Vienna, for instance) do not hesitate to come out openly for the "right to masturbate," and freely advise their patients, who for some reason cannot indulge in regular sexual relations, to practice masturbation.

CHAPTER FIFTY

TWO KINDS OF PREMATURE EJACULATION

A good deal of ignorance prevails on the subject of premature or precipitate ejaculation. People, both lay and professional, speak of premature ejaculation as if it were an entity with always the same etiology, pathology and treatment.

As a matter of fact, we have two distinct varieties of premature ejaculation, possessing a different etiology, a different symptomatology, and requiring diametrically opposite treatment. One variety is due to a hyperexcitability of the ejaculatory center, the man being sexually normal in all other respects — that is, his libido is unimpaired, the orgasm is normal, the pleasure of the act is normal, and the sensation of satisfaction and well-being after intercourse is as after a perfectly normal coitus. The unsatisfactoriness in this kind of premature ejaculation really relates more to the woman than to the man. He would not mind it much and would rarely come for treatment if the woman were not left in an unsatisfied, irritated condition.

The second variety of premature ejaculation is of an entirely different character. Here the libido is diminished. The erections may or may not be affected, but the orgasm is invariably diminished. There is little or no pleasure during the ejaculation. In fact, instead of any pleasurable sensation there may be a disagreeable scald-

ing or burning sensation in the urethra, and after the act the man feels disgusted, depressed, and generally cranky and irritable.

In the first variety of cases the urethral canal and the prostate are normal, the whole trouble being, as stated, in the hyper-excitability of the ejaculatory center. In the second variety there is usually atony or inflammation of the prostate and congestion of the posterior urethra.

The patients with the first variety of ejaculation are readily amenable to treatment. Instructions to restrain their ardor, together with a few doses of sodium or strontium bromide, are generally sufficient to produce an improvement or a cure. Patients of the second variety require all the physician's skill and patience and all the various measures, local, general, dietetic, hydrotherapeutic, etc., which we have outlined in the chapter on The Treatment of Sexual Impotence.

CHAPTER FIFTY-ONE

THE FREQUENCY OF COITUS

This is a delicate subject and still it has to be discussed, for patients often come to us with the question: Doctor, how often should a man have intercourse? or, What is the normal frequency of sexual relations? These questions show the patients' boundless confidence in the knowledge of the physician, whom they consider omniscient and infallible, and they also show the *naïveté* of the layman, who believes that iron-clad rules may be laid down for the exercise of any bodily function.

In no physical function do men present greater differences than in the sexual, and it would be fatuous to attempt to lay down any definite rule, to make a norm to which all men should conform. What is normal for one is decidedly abnormal or injurious for another; it may even prove fatal for that other.

The adage, "What is one man's meat is another man's poison," is very often literally true. And while the statement that "each man is a law unto himself" must not be understood literally, being true in a limited sense only, it finds its widest application in the human sexual sphere. As in the domain of the intellect we find such wide differences between two human beings as to make it difficult to believe that they belong to the same species, so in the sexual sphere we meet with variations which make it an utterly hopeless task to attempt to lay down definite rules,

and to make dogmatic statements. Intellectually we know that one man may be to another as 10,000 is to 1; sexually the variations are not so great, but even in this connection one man may be to another as 1,000 is to 1.

I will cite two cases which will show the absurdity of laying down any iron-clad rules as to the normal frequency of coitus.

Mr. A., 76 years old. Remembers distinctly to have had strong sexual longings at the age of six and seven and used to love to sleep with his little sister's wet nurse, to play with and fondle her. Had his first night emission when he was ten years old. Very soon after that began to masturbate, and masturbated two or three times a week regularly up to the age of thirteen. At that age he began to have normal sexual relations with married women and girl friends. He had relations on the average about once a week, and when for some reason he was unable to satisfy his desire in the normal way, he would masturbate. At the age of fifteen he became very friendly with a young widow, in the house in which he boarded, and for four years they had relations practically every night or every day. At first they would abstain during her menstrual periods, but after a while even the menses did not stand in their way. Sometimes they would have relations three to four times a day. During those four years he attended to his studies well and was in the best of health and spirits. At the end of that period, the widow, who was only thirty-six (he was nineteen) took it into her head to get married, and she did, and, *volens nolens,* after a debauch with her lasting four days and four nights, he had to take his congé. It affected him much more than he

thought it would; he was terribly upset, lost his appetite, slept badly and was unable to do anything. But in about two months his strong nature reasserted itself, he got into a liaison with another woman, and everything was again normal. During the following five years he led an exceedingly active sexual life, having had relations during that time with not less than twenty women. He often lived with two or three women at a time. At the age of twenty-four he got married. When he married he determined to lead a "virtuous" life. Unfortunately for his determination, his wife happened to belong to that class of angelic women who consider intercourse coarse and vulgar, and always submitted to it with bad grace; she belonged to the class of women who drive their husbands to other men's wives and to prostitutes. After trying for six months to live a strictly monogamic life, he gave up the attempt, for, as he said, life that way was not worth living. Not only was he depriving himself of what was to him the greatest pleasure in life, but he was feeling physically miserable and mentally wretched, and he was unable to attend properly to his very important responsible position. So he took up with other women. And to make a long story short, though in doing so I must leave out some very interesting details, I will say that he has had women friends ever since. Sometimes one, sometimes two, three or four at a time. And during that entire time he seldom passed a day without intercourse; very often he performed it three to four times a day. And all this time his responsibilities and his business were growing. From a manager he became a partner and then the sole owner of a million-dollar establishment. And he is a dynamo in work and he never gets tired. His first wife, who

considered intercourse a low and vulgar act and whom he soon left alone sexually altogether, though he treated her otherwise with the utmost consideration, "woke up," as he called it, when she was about thirty-five, and from that time until her death at the age of forty-eight he lived with her very actively, though he did not at all give up his other lady friends. A year after his wife's death, when he was fifty-three, he married again, a girl of twenty. They have lived very happily, and though she is forty-three now she looks no more than thirty or thirty-two. But he found that even she could not satisfy his needs, and therefore he did not dismiss his other liaisons. His wife is aware of them and does not mind them. So he says. She is sure of his love and is sexually fully satisfied.

What he came for is this. During the last six months he has noticed, he thinks, a weakening of his sexual power. The libido is just as great as it ever was, but he thinks the erections are not quite so powerful, and the ejaculation is somewhat premature. He looks at the thing philosophically. He knows he has had more than his share of the pleasures of life, and if I say that the weakening is physiological and that nothing can be done, well and good. He will moderate his sexual activities and will try to become reconciled to his fate. But if his weakness is due perhaps to some excess, and if it is possible to do anything for him, he would certainly like it done. He would like to have his sexual power last as long as his life.

On examination I found a powerfully developed man, with powerfully developed sexual organs. There was not really anything the matter with him, and after a few weeks moderation he reported to me that he was

as good as ever. Remember that he was seventy-six years old, going on seventy-seven.

As this was an interesting case, I discussed with him his history very fully. He assured me that several times he tried earnestly to moderate his sexual activity, but abstinence for several days was always accompanied by a heavy feeling in the head, discomfort, drowsiness, lack of ability to work, dragging down sensation in the perineum, feeling of distension and pain in the scrotum, etc., while intercourse was always followed by a buoyant happy sensation, by a desire to work and to be active. All the intellectual and somatic functions seemed to be stimulated. To a question of mine, he answered that he was sure that he would have gone insane if he had had to abstain for any length of time, say two or three months. He considers himself a good Christian (he is very prominent in his church), but he does not blame himself for his life: he blames nature for having endowed him with such extraordinary sexual capacity.

It is interesting to note that in spite of the hundreds of women with which the man had relations, not all of the women being his "friends," stenographers, secretaries, etc., but some belonging to the high demi-monde, he never had the slightest venereal infection. Whether this is due to the fact that the women all belonged to the somewhat better class and took care of themselves, or whether he has a certain natural immunity to thank for his good luck, is of course impossible to say dogmatically. My personal opinion is, that his immunity is the real cause. Without that immunity, it is inconceivable to think that he would not have been caught sometime or other. I have seen other

cases, which I could explain only by assumption of a powerful congenital immunity.

I might well say about this patient what Venette so well said about the strongly sexual in general: "One could more easily extinguish a great fire with a drop of water; one could more readily make a rapid river flow upward to its source, than to change the inclinations of such a man."

Here is the second case.

Mr. B. forty-two years old. I know the man well, and I have perfect confidence in every one of his statements. Here is his sexual history. Has never masturbated once in his whole life. Was very carefully brought up and did not know that there was such a thing as masturbation until he was twenty or twenty-two. At about twenty-one he had a night emission, which frightened him. He consulted the family physician, who explained to him its significance. Until his marriage he had emissions about once in three or four months. He would generally feel languid after them. He had an occasional desire for intercourse, but the desire was slight and he had no difficulty in overcoming it. Even if it had been stronger, his moral scruples and his fear of infection would have kept him from indulging in illicit relations. He married at the age of twenty-eight; for about four or six months he indulged every week or once in two weeks, then the interval was increased to once a month and then to once in two or three months. Once his wife had been away to her relatives for six months, and he was not bothered in the least, nor did he have a single pollution. Everything was going along smoothly, but three or four years ago his wife, who is four years younger than he, became more exacting, while he was getting weaker and his

desire was becoming less and less. At the present time, he has no desire whatever. He can have erections, though they are weak, and can perform the act, but it affords him no pleasure or satisfaction. In fact for two or three days after each act he feels a good deal of exhaustion and inability to work. He would be perfectly satisfied, in fact he would like it much better, not to have any intercourse for the rest of his life. He would not miss it and he would be able to attend to his work better. And if he were single, he would not think of consulting a physician. The reason he comes for treatment is — the wife. Her demands have remained quite exacting, and while she is very nice about it, he can notice that she is very dissatisfied and unhappy. He emphasizes and reiterates that nothing would please him so much as to be let alone sexually, but he is anxious to be treated for his wife's sake. On examination his organs, both penis and testicles, were found small and shrunken, and the prostate hyposensitive.

Now, here we have two cases. The contrast between them is striking, but neither of them is pathological; I did not select one with satyriasis, nor one suffering with impotence. They do not even belong to the domain of curiosities. While somewhat exceptional, they are strictly within the lines of the normal. Both have been normally married, both have had children, both are free from sexual perversions. In their conduct, in their work, in their social activities they are both considered even above the normal, and both enjoy the highest respect of their fellow-men. And still contrast the two. A's entire life is dominated by his sex instinct, though it does not interfere with his other activities. In B the sex instinct is

rather a useless appendage, more of a nuisance than anything else. It plays no rôle whatever in his life. It is A's boast that during his life he lived for a longer or shorter period, i.e. has had relations with, at least six hundred women; and he is not through yet. One woman has proved more than enough for B. I asked A to estimate for me approximately the number of times he had performed the act during his life, and after a little calculation he told me that a very conservative estimate would be between 45,000 and 50,000 times; 60,000 would probably be more correct. The number of times of B's sexual acts would be quite correctly expressed by one hundred. A can still keep up his sexual activity for several years if he does not die in the meantime, while B's sexual life is practically over.

Well, would you want to prescribe the same physical régime and moral code to A and B? Would it not be in the highest degree absurd to demand that A live according to B's standard or B according to A's standard? If you compare the two, you will see that A's sexuality to that of B is at least as is six hundred to one. Even these figures do not fully express the difference; they do not express the qualitative difference. And should we lay down the same laws for both?

I cited the two cases in order to impress upon the reader the vast differences existing in men in everything that concerns the sexual sphere; and it is as foolish and impossible to treat sexual disorders by a hard and fast rule as it is to demand the same sexual régime from people in health. Three hundred and sixty-five times a year may not be too much for A, while twelve times a year may

be too much for B. We must therefore strictly individualize each and every case.

I could relate dozens and dozens of cases illustrating the remarkable quantitative and qualitative variations in the manifestations of male and female sexuality. The above two should suffice to show how futile and fatuous it is to make iron-clad rules and categorical, dogmatic, ex-cathedra statements in reference to anything connected with sex.

If anywhere it is here that we must individualize and not jump at unwarranted conclusions from one or several cases.

But recognizing the absurdity of making a definite ruling in the matter, we may still attempt to discuss the proper frequency for the average man, leaving out of consideration the extremes at either end.

And I will give it as my dictum, that for the intellectual man of the present day, of the age between thirty and sixty, once a week is the proper frequency; for the non-intellectual man — by which I do not mean non-intelligent, but one who does not make his living by or devote his entire day to mental work — Luther's statement still holds good, namely twice a week. A greater frequency is *apt* to be injurious physically; while it is almost sure to take away from the intellectual man's capacity for work. He may not notice anything wrong, but if he observes carefully he will find that after frequently repeated intercourse he cannot work with the same intensity, nor for such a prolonged period. He may feel more buoyed up, he may even think that he feels more inspired after the act, but it will be of short duration, and the

sense of fatigue will supervene more quickly.

Some sexologists refuse to indicate the proper frequency of intercourse even for the average normal man by any figures. Their only criterion is the man's (or the woman's) feelings. But this is wrong.

A person's feelings are not always a safe criterion. A feeling of euphoria generally follows a great banquet, or the ingestion of alcoholic beverages, but if these indulgences are frequently repeated damage is sure to follow. The injurious effects of so many maladies are so slow in making themselves felt, so gradual and insidious in their onset, that the patient only becomes aware of them when the disease is fully established. Renal insufficiency may exist for years without the patient's knowledge, until one day he feels a very sick man and an examination shows that his kidneys are badly damaged and beyond repair. So a man may one day or one night suddenly, or almost suddenly, awake and find himself impotent. Perhaps if he had been a careful observer, he would have noticed that his libido was not so strong and spontaneous, that his erections were not quite so strong, or that the ejaculation was rather premature; but not all people are given to self-analysis.

Another bad thing about too frequent intercourse is that it — in a certain number of cases — is *apt* to create a habit, so that the man or woman feels the need of it more and more, and lack of it makes them feel miserably depressed, and affects them as badly as the sudden withdrawal of alcohol or morphine affects the alcoholist or morphinist. (However, complete abstinence for a while, and moderation after, are, as a rule, sufficient for a cure.)

CHAPTER FIFTY-TWO

"USELESS" SEXUAL EXCITEMENT

That useless, so-called frustrated, sexual excitement, excitement which does not end in natural satisfaction, is injurious, goes without saying. We have referred to this subject elsewhere. If continued too long, it is apt to lead to congestion of the posterior urethra and of the prostate, to pollutions, premature ejaculations, etc. But we have here another illustration of the danger of dogmatic and categorical statements in medicine.

While as a general statement it is true that frustrated sexual excitement is injurious, it is also a fact that to a large number of men and women it is not injurious; not only not injurious, but actually beneficial, serving them as a surrogate for natural intercourse. The subject is important enough to deserve a few additional lines. Many men are so situated that they cannot have intercourse. There may not be the proper opportunity, they may have an aversion to prostitutes, they may fear venereal infection, or they may have religious or moral scruples against illicit intercourse. And there is a large class of men and of women (a very large class, much larger than is generally believed to be the case) who are fond of the company of the opposite sex, but the fondness does not extend to actual coitus. In fact they seem to have rather a dislike for it. Now these two classes of men (and what is said in this connection about men applies almost with equal force to

women) if long deprived of female company begin to feel ill, depressed, nervous, fidgety and altogether out of sorts. But if they have a congenial woman for whom they have an affection, and whom they can fondle, embrace and kiss, they feel perfectly satisfied — as if they had natural satisfaction — and neither their sexual health nor their sexual power is in any way impaired. I have known men to keep up such relations for years and — provided the fondling does not go too far so as to amount practically to incomplete coitus — without injury. When they got married or took up sexual relations otherwise they found that their potentia coeundi was not in the least impaired. And many women have told me that the actual sexual act plays a very unimportant part with them, that they would just as lief go without, but they must have male company, they must be fondled and embraced by a man. If they are deprived of it for any length of time they feel very unhappy, depressed, melancholic, lose their appetite, begin to suffer with insomnia, and may become profoundly neurasthenic. And no medicinal, hygienic or any other kind of treatment is of any avail. The only cure is the company of a congenial male friend. On some even the mere proximity of a member of the opposite sex, without any kisses, embraces or fondling, acts as a balm and produces an unmistakably salutary effect.

It will therefore not do to say ex cathedra, as some sexologists with limited experience are in the habit of saying, that any *rapprochement,* any familiarity between the sexes not leading to the final act is injurious. For it is not so. The correct statement of the matter would be about as follows: *As a general rule,* sexual excitement in

man not leading to natural gratification is apt to be injurious; in some men close familiarity with the opposite sex expressing itself in the general term of fondling and kissing acts as a satisfactory surrogate for natural intercourse, and is to them not only not injurious but distinctly beneficial. Still more frequently is this true of women. Quite a large number of them who for some reason cannot or do not wish to have regular sexual relations get along quite well and are satisfied with the above described more or less platonic attentions from the male sex. Deprived of them for any length of time they suffer both physically and psychically.

In conclusion, it must be reemphasized that the fondling must not go too far, it must not go as far as touching and handling the genitals, because this is apt to go to the borderline of incomplete coitus and masturbation; this is an entirely different matter from mere "fondling."

CHAPTER FIFTY-THREE

THE RELATION BETWEEN MENTAL AND SEXUAL POWER AND ACTIVITY

The subject is large enough for a big book. I will limit myself to a few essential propositions.

What is the relation between sexual power and intellectual power? Is a high mentality ever the *result* of a powerful sexuality? No, no more than a powerful sexuality is ever the result of a high mentality. In analyzing men and women in this respect we may divide them into four classes.

Class one: Strong sexuality and strong mentality.

Class two: Strong sexuality and weak mentality.

Class three: Weak sexuality and strong mentality.

Class four: Weak sexuality and weak mentality.

From this classification it is at once evident that there is no *causal*, but only a coincidental relationship between sexuality and mentality.

With some people nature is extremely lavish and generous and she gives them an abundance of all her gifts; she gives them a strong physique, a strong mind and a strong sex feeling. To others she only gives one of these gifts, to still others she gives none. But each of these gifts is independent of the others. Strange as it may seem, there is even no direct causal relationship between a strong physique and a strong sexuality. As I have shown elsewhere, all-around athletes, splendid specimens of manhood, may

be pitiable sexually; while men who appear weak, undeveloped, anemic and altogether unpromising, may prove to be powerful sexually. And that the Latin proverb *mens sana in corpore sano,* a healthy mind in a healthy body, is false I have always maintained. Some of the world's greatest intellects resided in puny, weak, misshapen, dyspeptic bodies: sufficient to mention Voltaire, Rousseau, Kant, Carlyle, Schopenhauer; while that strong, well-developed powerful bodies may harbor the intellect of a tom-cat — to see this it is only necessary to look at some of our prizefighters, policemen and truckmen — and, yes, physical culturists.

And so, while a strong mentality and strong sexuality often reside in the same person, the former does not depend upon the latter and may be present in the total absence of the latter. If you will give me the names of Goethe, Dumas, Byron as examples and will try to deduce that their mentality must have been caused by their sexuality, then I will give you the names of Newton and Carlyle, the former of whom never had intercourse in all of his long life, and the latter of whom attempted to have but was unable to, because he was either completely impotent or at least very weak sexually.

We must differentiate between mental and sexual power and the manifestations of that power, i.e., activity.

Here we must also guard against unwarranted conclusions, and must not generalize from one or two cases. A friend of mine who always, sleeping or waking, has sex on his brain, and who wants to make everybody believe that sexual activity is the mainspring of everything that is going on in the world, pointed out to me with triumph the

case of a certain mutual friend of ours, who though nearer sixty than fifty is remarkably active both sexually and in his regular line of work. That man's activity in both directions shows no sign of diminution, and the number of his liaisons is just as large now as it was when he was thirty. And my friend believes that X's indefatigable energy in other lines is due to his sexual activity. But I could immediately show him the example of Y, who is just as energetic, just as incessantly active, just as indefatigable as X, but who has not had any sexual relations for 20 years. He is married to one of those sweet, pure New England women, who consider the sexual act shameful and nasty and permissible only under protest, as a necessary evil, when a child is desired. As a matter of fact, she is a frigid sexless creature who makes a virtue of her impotence; no woman with strong sexual desires considers the sexual act a shameful and reprehensible thing. She has some uterine trouble besides. Now, Mr. Y., very religiously brought up and socially so situated that he could not without great danger of being compromised indulge in irregular relations, decided from the very beginning, as soon as he recognized the nature of his wife, to cut the whole thing out. He suffered at first but possessing an indomitable will he determined to sublimate, to use Freud's expression, all his sexual power, to change his libido into other activities, to direct his energies into other channels. And he has succeeded. And for work he is as untiring as a machine, frequently working 16 and 18 hours a day at a stretch, for many weeks and months in succession.

So you see the case of X was completely neutralized,

more than neutralized, by the case of Y. We must not draw conclusions from single cases. We may use them as illustrations, but not as definite proofs.

Only in examining very large numbers of cases are we justified in drawing tentative conclusions. When we analyze a large number of cases in reference to the relationship between their sexual and mental activity, what do we find? We find three classes of cases.

Leaving out of consideration those whose mentality or intellectual productivity is so slight that it makes no difference what they do or don't do, we encounter the following types.

Class One. Sexual activity seems to produce no appreciable difference. Intercourse neither stimulates nor depresses them. They may indulge frequently or abstain, their intellectual output is not influenced one way or another.

Class Two. On people of this class sexual intercourse has a decidedly stimulating buoying-up effect and they prove the falseness of the Latin adage, which we see repeated parrot-like in many books dealing with the sex question, namely: *omne animale post coitum triste,* that every animal is sad or depressed after intercourse. It may be true of other animals, and it is true of a certain class of men and women, but it is decidedly not true of the majority of the human race. This class of people get a new stimulus to work, work better and harder, get new inspiration, new ideas, after sexual relations.

And the sad truth must be told that this stimulus, buoyancy and inspiration are particularly marked if these relations are with different women, with new women. But it

must also be stated that for this stimulus and inspiration actual intercourse is not necessary. Many men and women get the same stimulus from falling in love, from relations which are of an entirely or of a more or less platonic character.

In examining into the subject we will find that a very large percentage of people of class *two* are writers, poets, artists, painters and sculptors, dramatists, etc., or people of an artistic and imaginative temperament. In this class will be found very few if any people of a scientific bent of mind, very few if any scientists, research workers, inventors. And one will surely not find any mathematicians in this class. It seems that purely intellectual, i.e., scientific, philosophic and mathematical activity, differs in kind from artistic activity; and while sexual activity is not incompatible with the latter, it is distinctly antagonistic to the former. Love, using the word in its French sense, is a good stimulant to brief spurts of intense work, it loosens the wings of the imagination, but is not a good spur to long sustained work, requiring patient research and carefully worked out thought and analysis. Scientists and mathematicians ought to leave the shrine of Venus alone; and they generally do — to the benefit of mankind, but the dissatisfaction of their wives.

Class Three. On people of this class intercourse has a most ruinous, I might say, stunning effect. A single performance of the act will incapacitate them for any mental work for days. Some experience a feeling of actual emptiness in their heads — they so express it — and feel in a somewhat dazed condition. It takes them three, four, five days, in some cases as long as two weeks, to recuperate from

the shock, for on them intercourse has the effect of a shock.

The chemical composition of the brain is very closely related to that of the seminal fluid, and these people seem to be endowed with just so much vitality. They can use their brain or their sexual organs, but they cannot burn the candle at both ends. They cannot worship at the shrines of Minerva and Venus at the same time, as some other lucky individuals can; they must give up one or the other, and as a rule it is best for them to give up Venus. They generally find this out themselves, and I know of some people of this class, who, when they have some important work to do, a book to get out, abstain altogether for several months, for a year or two.

I now come to an important point, the influence of the physiological extinguishment of the sexual power, the withering or atrophy of the sexual organs, on man's mentality. This presents a very important practical question, a vital question. The question is: Does physiological sexual impotence coming on in men of between 45 and 65 drag in its wake also a weakening of mental powers: and if so, is it possible to delay by treatment the oncoming of impotence and *thus* delay the sad advent of intellectual decay? Here again one answer will not cover all cases. In some men the decay of the sexual power passes off imperceptibly, without any apparent influence on their mentality one way or another. In others, a small number, it is true, intellectual *activity*, the intellectual *output* is even increased. I should not be willing to assert that their intellectual *power* is increased, though even that is possible. It is possible that the vital fluids which were used up before

for the manufacturing of the testicular secretion are now utilized by the brain. But the explanation is probably a simple one: Having lost their desire and their power, having lost their interest in women — or women having lost any interest in them — those men have more time and energy to devote to their other interests, and they thus accomplish more work.

The limits of some people's activity are strictly circumscribed, and if they spend a good deal of their time and energy in running after women, their work is necessarily neglected.

But in the large majority of men we find that either the physiological, i.e., normal, or premature decay of the sexual power does have a deleterious influence both on intellectual power and intellectual activity; perhaps it would be more correct to say that the decay of their sexual power goes *pari passu* with the decay of their intellectual power. But whichever it be, whether the relationship be causal or merely synchronous, coincidental, the very important fact remains that by treating a patient so as to stay off his sexual decay, we succeed at the same time in a large number of cases in warding off, in staying off, the weakening of the mental powers. And the frantic rush of so many men to get treatment when they notice that they are getting weak sexually has its justification. Overstimulation is injurious, but proper stimulation is useful for any organ, for any function; and it so happens that many of the remedies useful in treating sexual weakness, such as lecithin, testicular extract, spermin, etc., are also useful for the brain and nervous system. And, besides,

by stimulating the testicular function, we help to generate a certain something which acts as a stimulant to the cerebrum and the entire nervous system.

We want to bear in mind that the old idea that the testicles generated only spermatozoa is erroneous. We know now that the sexual glands generate at least four different substances: The spermatozoa which are necessary for the perpetuation of the species, an erogenous substance called libidogen which serves to stimulate the sexual desire, a third substance which gives the man the male characteristics, i.e., the general structure of the body, the beard, male voice, etc., and a fourth substance which acts as an energizer and stimulant to the entire organism — the body, the viscera, the brain and the nervous system. And what is true of the testicles in relation to men is true of the ovaries in relation to women. The sexual glands may be deficient in one of these components and be normal in the others; thus for instance a man's testicles may manufacture absolutely no spermatozoa, and still he may be strongly libidinous, potent and robust in all other respects. It is probably due to this fact that the decay of the sexual power, the atrophy of the sexual glands, has such a variable effect on different people: It depends upon which constituent of the sexual secretions is most deeply affected. If the libidogenous or generally energizing substances are at fault, we can replace them to a certain extent from without by proper medication and we can also stimulate the sexual glands to greater production.

It is therefore not only justifiable but advisable that people who find that their sexual vitality is being drained away prematurely, as well as those who find that their

vanishing potency goes hand in hand with a vanishing brain power, should do their utmost to stay the process of decay.

While we have not yet discovered the fountain of perpetual youth and perennial sexual vigor, we do possess remedies that help us to fight off the premature approach of sexual decay, and to delay for several years the unwelcome arrival of sexual and mental senility. While this is not everything, it is something worth while.

CHAPTER FIFTY-FOUR

OMNE ANIMALE POST COITUM TRISTE

Though I have touched upon this point in the preceding chapter, it is worth while to devote a few more words to it.

Many adages and proverbs have been handed down from generation to generation and have been accepted without question or analysis as axiomatic truth. The statement in the title, "Omne animale post coitum triste," that every animal after coitus is sad or depressed is one of these adages. It is to be found in every book dealing with the effects of sexual intercourse, and it is accepted as such a self-evident truth that it needs no discussion. Nevertheless it is false as applied to human beings. I am not in a position to speak of the effects of coitus on the spiritual condition of animals, but I repeat it is decidedly false when applied to human beings.

That some men and women feel sad and depressed after coitus is of course perfectly true, but then there is always something wrong either with the man or woman or with the coitus. The feeling after normal satisfactory coitus is one of buoyancy, stimulation, springiness, brightness of mind and of eye, a desire to work and the capacity for work. There may be a temporary languidness for a time after the act, but this does not interfere with the correctness of the symptoms following normal coitus as just mentioned.

Whenever depression or exhaustion follows the act of

coitus then we may be sure that there is something abnormal. Either the persons are neurasthenic, impotent or otherwise ill, or the man and woman in the given case are not compatible for some reason or other, and do not mutually satisfy each other. For it is a well known fact that a man may feel depressed and exhausted after coitus with one woman and feel well and buoyant after coitus with another woman.

It is time that the adage, omne animale post coitum triste, be thrown out from our books dealing with sex, for it is certainly the opposite of true when applied to normal, healthy human beings.

CHAPTER FIFTY-FIVE

SEXUAL VIGOR AND BIG FAMILIES

The subject of sex is covered with ignorance and honeycombed with error. I have exposed many errors which have generally been entertained by the laity, as well as by the medical profession, concerning the manifestations of the sex instinct, and I believe that I have succeeded in shedding a little light on the subject. Here is another crass error which it is necessary to combat.

The opinion is generally prevalent among the laity that sexual vigor is closely connected with large families, that the father of many children is necessarily a sexually powerful man. The salacious remarks made when a father happens to pass by with many children by his side is sufficiently indicative of the layman's opinion. But unfortunately it is not only the laity that has such an opinion. The medical profession shares in the same error. In fact, as I have shown many times before, there is hardly an error entertained by the laity regarding sexual matters which is not also shared by the average physician.

For instance in a pamphlet recently issued by a medical society which considers it its duty to prove to the public that the sexual instinct was given to man by nature by mistake — that there is no necessity whatever for satisfying that instinct before marriage, and after marriage only because a certain amount of indulgence is necessary for the reproduction of the race — the writer desiring to prove

its contentions has recently made the statement that lay brothers who lived in monasteries for many years without any sexual indulgence and afterwards went back into the world and got married, often became fathers of very large families. All this shows a deplorable confusion not only in the lay but also in the medical mind of potentia coeundi with potentia generandi. It certainly should not be necessary at the present day to have to emphasize that one is to a very great extent independent of the other.

This connecting of large families with sexual vigor is absolutely erroneous. Strange as it may seem at first glance, but as I will have no difficulty in proving, just the contrary is very frequently the case. I have personally known and had under my treatment very numerous cases of men who were practically impotent as far as erection is concerned, but who were the fathers of very large families. Consider how little is necessary to impregnate a woman. The mere deposit of a few drops of semen near the fourchette is sufficient, and a man with small, shrunken organs, the most rudimentary erection and premature or precipitate ejaculation may impregnate his wife just as often as she is capable of being impregnated. I have seen many such cases.

In fact personally I have the conviction that the sexual weakling, provided his semen is normal, is more apt to and generally does more often impregnate his wife than the sexually vigorous man does. And the reason is a twofold one. First of all, the sexual weakling has no will power, and while his libido sexualis is weaker than in the sexually vigorous man he is less able to restrain himself, and so at the merest desire for intercourse he practices it. It is only

in the unmarried state that the sexual weakling practices sex relations less frequently than the sexually vigorous man, because then he has obstacles to overcome, there is trouble, there is fear of venereal infection, discovery, expense, etc. These considerations are often sufficient to overcome his weak desire, but in the married state he invariably abuses his wife much more than the sexually strong man does. It is only when the impotentia erigendi and the ejaculatio precox are combined with a lack of libido that he is apt to leave his wife alone, though even then not always. I have known patients who confessed to me that they had no desire, that the act afforded them no pleasure, and still they did it out of dullness or to satisfy some indefinite irritation. Secondly, the ejaculation of the sexual weakling being premature or precipitate, he is unable to practice coitus interruptus or reservatus (he is even mechanically unable to practice coitus condomatus which the strong man often does), which the sexually vigorous man often does.

For these and other reasons which cannot very well be discussed in print even in strictly scientific treatises, I have come to the conclusion that in a large percentage of cases it is the sexual weakling who is the father of many children and the sexually strong man who is the father of a moderate progeny.

In one morning recently I had two patients, one forty-eight years old, the father of ten children, the other thirty-five years old, the father of six children. Both suffered from weak erections and premature ejaculations from the very first day of their marriage.

CHAPTER FIFTY-SIX

SEXUAL PERVERSIONS

I touch but lightly upon the subject of sexual perversions, devoting but a brief chapter to it, not because psychopathia sexualis is a nasty and disagreeable topic, but for the following reasons: (1) This book deals with disorders of sex which are amenable to treatment — curable or improvable. The perversions are as a rule not amenable to treatment, and certainly not at the hands of the general practitioner for whom this book is written. They belong in the hands of the psychiatrist and sexologist. (2) The subject is large and complex enough to require a whole book to itself. (3) The subject has been handled in a thorough manner by others — Krafft-Ebing, Ellis, Moll, Eulenberg, Bloch, Hirschfeld, etc.— so that to write briefly on it would mean merely to condense, to transcribe, or to excerpt from what others have written. (4) And, last but not least, cases of sexual perversions are not apt to apply to the general practitioner for treatment — not in this country, at least. If I do devote here a few paragraphs to them, it is because it is *important* that the physician should know that such cases exist. The college and the textbooks are silent on the subject; but in my opinion the medical practitioner should be familiar with all the disorders, abnormalities, vagaries and perversions of the sexual instinct.

Satyriasis means insatiable sexual desire. This term

should not be applied to increased libido, in which the person while having excessive desire can still control himself; nor should it be applied, though it frequently is, to cases of excessive libido in which the cause can be found in an inflamed prostate or posterior urethra. Satyriasis is correctly applied to that excessive libido which is of cerebral origin, which is all-absorbing and all-engrossing, which forces the man sometimes to commit rape or other criminal acts, and which is insatiable. That is the man has as much or almost as much desire immediately after intercourse as he had before.

The only treatment for true satyriasis is confinement (in a hospital or sanitorium) the continuous cold bath or cold pack and immense doses of bromide and chloral. I would not hesitate to keep an unfortunate victim of satyriasis under a semi-narcosis for several days at a stretch, or several weeks if necessary. Castration may be considered, though we need not promise ourselves too much from the operation. For a time at least the insatiable libido may remain unchanged; in time however castrates generally lose their libido.

Nymphomania is insatiable sexual desire in women. It corresponds to satyriasis in men. The unfortunate victims of this disease are often forced to become common prostitutes in order to be able to satisfy their desires. If they cannot get natural satisfaction, they masturbate excessively. Many of them end in the lunatic asylum. Sometimes nymphomania is the initial symptom of a severe psychosis. One of the saddest cases of nymphomania that I know of was in the beautiful daughter of a well-known physician. The mother was also apparently somewhat of a nympho-

maniac, but the condition assumed an extreme form in the daughter. She would accost and force herself upon her father's patients, and the father had to move from place to place. She finally entered a house of prostitution, where she later committed suicide by throwing herself out of a third story window.

The treatment of nymphomania is similar to that of satyriasis: Confinement, continuous cold bath or pack, immense doses of bromide and chloral and morphine if necessary. Removal of the clitoris may be considered. I consider even removal of the ovaries justifiable, if we could be sure of satisfactory results. Unfortunately we cannot, for nymphomania like satyriasis, is of cerebral origin, and the removal of the chief sexual glands may not accomplish any noteworthy results.

Homosexuality

The most important of the sexual aberrations or perversions is homosexuality. The normal instinct is hetero-sexual, that is each sex is attracted by the opposite sex, the male by the female, the female by the male. In a small percentage of cases, however, the attraction is for members of the same sex.

The true homosexual is entirely indifferent to members of the opposite sex. They have no attraction whatever for him, and in fact he may have the same loathing for them sexually as the normal individual has for members of his or her own sex. In other words, the homosexual man means a being with the body of a man but with the soul or sex instinct of a woman, the homosexual woman is a being with the body of a woman and the soul or sex in-

stinct of a man. And the term, "the third sex," which is applied to such persons by some sexologists, is not inappropriate.

It used to be thought that homosexuality existed only among idiots and imbeciles and the lowest class of degenerates. This, of course, has been shown to be an error. On the contrary, some of the world's great poets and artists are now known to have been and to be homosexual.

As to the frequency of homosexuality, of course no exact figures are available, but Dr. Magnus Hirschfeld, who has done so much work for the creation of a better and saner attitude towards the homosexual, made a very thorough investigation of the subject, sending out question sheets to thousands of people, and his conclusion is that in Germany the number of homosexuals reaches 2 per cent. This refers to true homosexuals who have an aversion to the other sex. If we include in the number also the bisexuals — that is, those who are attracted by both sexes, though their preference may be for their own sex — the number reaches the high figure of 6 per cent. This figure closely corresponds with Havelock Ellis's figure, which is 5 per cent. for homo- and bi-sexuals.

The feelings of the true homosexual for the object of his love, which is of course a member of his own sex, differ in no way from the feelings which a normal person in love has for his object of the opposite sex. Their attachment often reaches the highest degree of intensity; and their jealousy is so extreme that when the object of their love, who often may happen not to be homosexual, leaves them or gets married, they not infrequently commit suicide.

The homosexual may be loathsome to us, and as far as the race is concerned they are a *lusus naturae,* and I personally cannot bring myself to regard them sympathetically, but we want to get rid of the crude and coarse idea that the homosexuals are all low degenerates and criminals. They count among them some fine and gentle souls, and outside of this sex aberration they may be normal in every other respect, though as a rule they are shy, timid and retiring. This, however, is easily explained by their knowledge of the contempt in which they would be held by the rest of the community if their abnormality became known.

While homosexuality among males is punished severely in most countries, there is now a strong movement in Germany, and in some other countries, to abolish all laws against homosexuality where practiced between adults and where the element of force is excluded.

We must distinguish between true homosexuality and those cases of homosexual relations which take place among people who are forcibly deprived of the company of the other sex, be it in prisons, barracks, ships, boarding schools, convents, etc. These practices are indulged in *faute de mieux* as a necessary evil. When the conditions are changed those persons go back to normal sexual relations.

We must also exclude from true homosexuality those cases of pederasty (sexual relations with boys) which are indulged in by depraved roues, either young or senescent, to whom the ordinary stimuli are no longer sufficient.

Treatment. For the true congenital homosexual there is no treatment. We can sometimes accomplish some-

thing by teaching him to improve his will-power, and advising him to become interested in things which would engross his entire attention and energy. In bi-sexuals, and in those in whom the homosexuality is of an acquired character, much can be done by suggestion and by proper company of those of the opposite sex. For the welfare of the race, however, it is better that homosexuals and bi-sexuals never leave any progeny, because there can hardly be any doubt that heredity plays a very important part in sexual abnormalities.

Fetishism

Fetishism is a peculiar perversion in which an inanimate object, generally an article of female clothing, acquires a high sexual significance. We can divide the fetishists into two classes, one more extreme and pronounced than the other. In the first, the most extreme class, the fetishist has no desire for any woman, and he usually has never had any intercourse with a woman. He finds his sexual gratification in the object of female clothing, most commonly a female shoe. He goes to bed with that object, he fondles it, and the presence of that object causes intense sexual gratification with ejaculation. The second class of fetishists do have desire for women, and do have natural intercourse, but the fetishistic object acts as a stimulus, as an excitant. They cannot have an erection or ejaculation unless they have their fetish near them. In this class of fetishism may also be included the cases where the man is able to have sexual relations only with women who are dressed in some peculiar fashion or costume. The variety of objects which serve as fetishes to

perverted men is very large, but their enumeration would serve no useful purpose in a book of this character.

Most cases of fetishism are amenable to treatment. Treatment is of course principally suggestive in character, and no success can be expected unless the patient has absolute faith in the physician's ability to cure him. I have had several cases of fetishism in whom the results of the treatment left nothing to be desired. Hypnotism has also been used successfully. And those who practice Freud's psychanalysis claim very good results in this class of cases.

Of course no medicinal treatment can be of any avail in the above class of cases. Medicinal treatment may be given for a general tonic and suggestive influence, but the real methods of treatment are psychotherapy, suggestion under hypnosis, and Freud's psychanalysis.[1]

[1] The technique of Freud's psychanalysis is too complex to be described here in detail, or to be applied by the general practitioner. It may be described briefly, however, as the disclosure of the patient's mental processes and the peculiarities of his sexual impulses by an analysis of his dreams, of the ideas and trains of thought associated in his mind with various words, and of the subconscious memories and impulses of early life uncovered by skillful questioning of the patient after the resistance and "censorship" of his conscious mind has been overcome by a low degree of hypnosis. By these methods the original source of the patient's sexual abnormality, which is usually to be found in some powerful impression and association of ideas in adolescent or infantile life, is discovered. The revelation and explanation to the patient of the source of his "obsession" or neurosis, combined with suggestion and whatever physiologic measures may be necessary, is said frequently to have a surprising therapeutic effect. When the source of his or her association of certain ideas with the sexual impulse is brought into the light of day and understood by the patient him-

Sadism is a perversion consisting in the passion to inflict pain upon the sexual partner. From the mild and innocent love-slap or love-pinch or love-bite, it increases gradually to the highest forms of brutality and cruelty. Most of the sadists are among men, very few among women.

Masochism is a perversion consisting in a desire to be maltreated by the sexual partner. It is a mistake to think that masochism is to be found only among women. There is a very large class of masochists among men; and the cruelties which the masochists, either men or women, insist should be inflicted upon them are sometimes incredible.

Severe flogging, to the point of producing welts and blood, is one of the forms of cruelty liked both by the sadists and the masochists. The sadist finds his highest

self, it tends to disappear. Freud's theory is built upon the idea that the sexual impulse is much more complex in its nature and widespread and diffuse in its effects on the whole personality than has heretofore been recognized, and that the formation of this impulse begins in infancy and can readily be disordered or warped in its development, especially in neuropathic types, by early experiences and associations of sensations and ideas which seem to be very remote from the specific sexual impulse itself. It is obvious, however, even from this brief explanation, that Freudian psychanalysis is a method of investigation and treatment which cannot be intelligently or safely used except by those who have made a special and thorough study of the method in all its phases, and who can devote to each patient the usually considerable length of time required for its successful application. In the hands of a non-competent or tactless physician psychanalysis is practically sure to prove useless or to do actual harm. To those who are interested in the subject Freud's "Three Contributions to the Sexual Theory," and his "Interpretation of Dreams," and Brill's "Psychanalysis" may be recommended.

erotic gratification by flogging his partner and the masochist by being flogged. Both sadism and masochism are known under the term algolagnia. Those suffering from these forms of perversion, particularly the sadists, are often true psychopaths, and should, for the safety of the community, be locked up.

Other Perversions

Bestiality refers to sexual relations with animals. This form of perversion is common only among idiots or imbeciles, or among farm-hands of a very low type who are deprived of any other form of sexual relations.

Pygmalionism is a perversion in which the erotic desire is excited by statues and figures. I have had a patient who would go frequently to the Museum of Art and would there masturbate in front of one of the female statues. This is a very common condition among boys, and this peculiar abnormality refers to statues only. Erotic desires awakened by naked women, lewd pictures or salacious literature is of a different character.

Narcissism is that peculiar form of perversion in which the person is in love with his or her own body. He or she will admire his or her body in the mirror, sometimes for hours at a time, will pat it, kiss it, and so forth. In the extreme forms of narcissism the person has an aversion for any other person but himself or herself. This is the highest form of auto-eroticism.

Exhibitionism is that form of perversion in which the person deliberately and shamelessly exhibits his or her genitals, particularly to members of the opposite sex. Exhibitionism undoubtedly belongs to the psychopathies, and

the exhibitionist, male or female, sooner or later falls into the clutches of the law.

Necrophilism, the lowest and most horrible form of perversion, consists in sexual desire for dead bodies. The only treatment of such perversions is the asylum for the insane.

There are other forms of perversion which perhaps might more correctly be termed depravities. Thus, for instance, we apply the term *Voyeur* or *Voyeuse* to the man or woman who finds his or her highest sexual satisfaction in watching the act of coitus performed by others.

Frotteur is a term applied to the person who finds sexual satisfaction in rubbing against and feeling the bodies of others. Many *frotteurs* can be found wherever there is a big crowd, in crowded cars, in the rush hours in the subway, in crowded meetings, in menageries, and so forth. Some quite eminent and otherwise respectable people are the victims of this form of perversion.

CHAPTER FIFTY-SEVEN

THE PREVALENCE OF SEXUAL IMPOTENCE AND OTHER SEXUAL DISORDERS.

We can know the exact or at least approximate percentage of typhoid fever, of pneumonia, of tuberculosis or of any other reportable disease. As to the prevalence of diseases which are not reportable we can only guess, and our guess may be wide of the mark. The guess will of course vary with the character of the physician's practice; and even his exact figures, if he keeps careful account of his cases, will merely represent the percentage in his practice. Leaving out altogether the specialists in diseases of the eye, ear, nose and throat, the surgeons, orthopedists, etc., even the general practitioner may not have more than one or two per cent. of cases of sexual disorders to *treat*. First, because the general practitioner does not question his patients about their sexual affairs; and second, because even if questioned the patient is apt to deny to his family physician that there is anything the matter with him sexually: his sexual life he prefers to disclose to the specialist only. The percentage of sexual patients in the practices of genito-urinary specialists will also vary greatly. Some will say that they see about 5 percent, others 10, others 25 percent of sexual disorders in their practice. It depends a good deal on what special branch of one's specialty one specializes in particularly.

In the beginning of my genito-urinary practice my sex-

ual cases ranged between ten and twelve percent. But the percentage has been gradually growing higher, so that now, in some weeks or even months, it constitutes 50, 60 and 75 per cent of the total number treated. For instance, last Sunday I saw at my office 29 patients. Of these 17 were sufferers with sexual disorders of one kind or another, 7 had gonorrhea, 2 had syphilis, 1 psoriasis, 1 eczema, and 1 had absolutely nothing the matter with him.* Of course it would be absurd to judge from this as to the relative percentage of these disorders in the community at large; they simply indicate the character of one physician's practice.

But in spite of my or anybody's inability to give exact figures we cannot help forming impressions and having opinions. And I have long ago formed an impression as to the prevalence of sexual disorders, and I give here my impression for what it is worth. My impression is, startling as it may seem, that *at least fifty per cent* of the adult population of any civilized community suffer with sexual impotence or some other sexual disorder.

A careful man does not form his impressions out of thin air, and my impression certainly has a definite foundation. I know so many men who are considered by everybody, *including their family physicians,* perfect specimens of manhood and who are to my knowledge sexually crippled, that I do not pay much attention to a man's exterior. Neither a man's stature, nor his well developed muscles, are indica-

* He had a minute, hardly visible pimple on the glans. He had gone to an advertising quack, who told him that he had syphilis and promised to cure him for $150. But the quack was so anxious to get something on account that the patient got suspicious, and on the advice of a friend came to consult me. I told him to go home and forget it.

tions of his sexual vigor. And we must bear in mind that tens of thousands of people who are sexually weak never apply to a physician. A man with gonorrhea or syphilis is sure to seek the doctor's aid. Not so with a sexually impotent man. There are thousands of unmarried men who go about with their infirmity for years, until they suddenly meet their affinity and decide to get married. Thousands of impotent married men whose wives are frigid never consult a physician. And it is my belief that for every sexual impotent who consults a physician there are ten who do not. And I consider my opinion, that about fifty per cent of the adult population, male and female, in every civilized community are suffering from some kind of sexual disorder (outside of venereal disease), fully justified.

PART IX

PRESCRIPTIONS

CHAPTER FIFTY-EIGHT

PRESCRIPTIONS AND MINOR PRACTICAL POINTS

There is a prejudice in certain quarters against Prescriptions and Formulas. To a certain extent I share in this antagonism. There should be no need for Prescription Books and Formularies. Every physician should be able to compose his prescriptions extemporaneously to suit each individual case. But we must take the world as it is, not as it should be. What are the facts? The facts are that many, many physicians (their number runs into the thousands and tens of thousands) cannot satisfactorily combine several ingredients into one mixture. The result of their attempted combination is apt to be a physical impossibility, a chemical incompatibility, or a therapeutic absurdity. Very often, they are not quite sure how to write the prescription even for a single ingredient. For instance, it happened to me more than once when a physician would bring his patient for consultation, and I would among other things advise him to administer some glycerophosphates, or some thyroid, or a preparation of the suprarenal gland, the physician would add: How do you prescribe those things? Are they solids or liquids, etc.? Somebody might interject here the remark that such physicians have no right to practice medicine. To this I would say that such severity is uncalled for. A physician may not be

MASTURBATION

℞ Sodii Bromidi ..... ℥ss
Strontii Bromidi.... ℥ss
Ess. Pepsini (Fairchild .... ℥jss
Aquae Menthae Pip. q. s. ad .... ℥iij

S. ʒi at 7 P. M. and on going to bed.

(Contains 10 grs. of each of the bromides to the dose; in mild cases, or for young boys and girls.)

℞ Sodii Bromidi ..... ℥j
Strontii Bromidi .. ℥j
Elixir Peptenzyme.. ℥j
Aquae q. s. ad..... ℥iij

S. ʒi in water at 8 P. M. and on going to bed. In severe cases may be administered 3 times a day.

℞ Potassii Bromidi... ℥ss
Sodii Bromidi .... ℥ss
Strontii Bromidi. .. ℥ss
Elixir Lactopeptine, ℥jss
Aquae ad .... ℥vi

S. ℥ss in water on going to bed; or at 7 P. M., and on going to bed; or three times a day. Or the dose may be administered about an hour before the desire to masturbate usually comes on. For in some people the masturbatory attack is more or less periodic.

Where the patient masturbates excessively at night, and suffers with restlessness and insomnia, or simply poor sleep, we are justified in administering a somnifacient. The inability to gratify sexual desire normally leads to insomnia, and the restless insomnia often leads to masturbation. A vicious circle is thus established, and it is our duty to break up the vicious circle. For this purpose we may combine chloral with the bromides, as follows:

℞ Potassii Bromidi ... ʒj
Sodii Bromidi ..... ʒij
Chloral .... ʒi
Elixir Simp. .... ℥ss
Syr. Aurantii ..... ℥i
Aquae q. s. ad...... ℥iv

S. ℥ss on going to bed.

Or instead of the above mixture we may administer some of the well known hyp-

notics, such as veronal in 7 to 10 grain doses, or veronal and trional 5 grains each. Morphine should not be administered under any circumstances, first for the fear of establishing a habit, and second, because morphine, as may or may not be known, has the tendency in many cases to excite the sexual desire.

To any of the bromide mixtures we may add in order to somewhat counteract their cardiac depressing effects, either digitalis or strophanthus — 2 to 5 min. to the dose of tincture of digitalis or tincture of strophanthus.

As stated in the text I also use the suprarenal preparation for that purpose; it is possible that they also possess some specific tonic effect. You may prescribe them in the following formula:

℞ Sol. Adrenalini Chlor.
(1:1000) ....℥j
S. Gtt. v-x t.i.d. in a little water.

Instead of adrenalin the equivalent preparations of the active principle, known commercially as supracapsulin, epinephrin, adnephrin, etc., may be prescribed. Or instead of the active principle we may prescribe the dried suprarenal gland itself. As follows:

℞ Tab. Gland. Suprarenal. sicc. U. S. P. āā gr. v.
No. xxiv.
S. One t.i.d. p.c.

Instead of simply writing U. S. P., it is, however, preferable to specify the brand of a reliable house, such as Burroughs-Wellcome, Parke-Davis, Armour, etc. The organotherapeutic preparations, unless obtained from firms of the highest standing, are apt to be inert or to possess little therapeutic value.

Thyroid may be prescribed in the form of the dried thyroid gland, or best in the form of tablets put up by various high class firms, as follows, for instance:

℞ Tab. Gland. Thyroid.

sicc. (Burroughs-Wellcome) āā gr. v. No. xxiv.
S. One t.i.d. p.c.

Instead of the gland itself, we may prescribe the various preparations, which are on the market, for instance, Thyraden (3 grs. t.i.d.), Thyroidin (1 to 3 grs. t.i.d.), Iodothyrine (5 grs. t.i.d.).

Though mentioned in the text, it may be repeated here that thyroid preparations are not to be given to a patient, unless we can see him frequently, at least once a week.

℞ Tab. Trit. Atropinae Sulph. āā gr. 1-150 No. xx.
S. One t.i.d. or as directed. Not to be repeated without my written order.

An Excellent Sedative Ointment (in Pruritus, etc.)

℞ Morphinae Sulph. gr. iv
Cocainae Hydrochlor gr. iv
Zinci Oxidi......ʒij
Bism. Subnitr. ..ʒi
Phenolis ....gr. x
Petrolati ....℥ss
Adipis Lanea ...℥ss
M.f. unguentum
S. Apply 3 times a day.

In Itching of the Genitals

℞ Menthol ....gr. v
Phenol ....gr. x
Cocainae ....gr. v
Zinci Ox. ....ʒij
Bism. Subnitr.....ʒi
Vaselini Albi .....℥i
S. Apply 3-4 times a day.

℞ Ac. Nitrici U. S. P..ʒss
S. Use externally as directed, with glass rod.

POLLUTIONS

℞ Tr. Ferri Chloridi ...ʒvi
Tr. Cantharidis .....ʒij
S. Gtt. ij-vii in a little water (preferably Vichy or Seltzer) t.i.d.

℞ Strontii Bromidi....ʒiv
Sodii Bromidi ....ʒiv
Elixir Lactopeptine, ℥jss
Aquae ad ....℥iv
S. ʒj at 4 P. M., at 8 P. M., and on going to bed. (Of course instead of the elixir lactopeptine another digestive vehicle, such as essence of pepsin

or elixir peptenzyme, may be used.)

As will be seen, I use in pollutions and spermatorrhea smaller doses of the bromides than I do in masturbation, and I never use the potassium bromide. Once in a while I prescribe the organic preparations of bromine, such as Bromural; but while these preparations are useful in general nervousness, in pollutions the inorganic bromides are more effective.

℞ Strontii Bromidi...gr. v
Camphorae Monobrom ....gr. ij
Lupulini Optimi ..gr. v
Hyoscinae Hydrobrom ......gr. 1-100
M.f. caps. No. 1.
S. One on going to bed. In obstinate cases an additional capsule may be given at 8 P. M.

LAXATIVES

It is superfluous to give formulas for laxatives, as patients differ so widely in this respect. I merely wish to emphasize the care necessary in avoiding any cathartic which has a tendency to irritate the lower rectum.

A good dose of some of the laxative mineral waters, like Hunyadi Janos or Apenta, is generally the best. A tablespoonful of the old-fashioned compound licorice powder (Pulv. Glycyrrhizae Comp. ℥iv.) ℥ss on going to bed is very efficient. I never prescribe glycerin suppositories in cases of pollutions or spermatorrhea, for I convinced myself that they *irritate the prostate;* the defecation following the use of a glycerin suppository will often be accompanied by a discharge of fluid from the prostate or seminal vesicles even in patients who otherwise did not suffer from defecation spermatorrhea. Gluten suppositories do not exert this irritating effect. The gluten suppositories are introduced on going to bed, and the action takes place in the morning. Phenolphthalein I object to, as it upsets the digestive functions.

Of course it is still better to

so regulate the patient's diet that he may not be in any need of laxatives. Good raw prunes, or a compot made of prunes (known in German-speaking countries under the name "povidl") and figs are often in themselves sufficient to establish a free and regular movement. Prunes to exert their best effect should be taken before breakfast; figs, on going to bed.

IMPOTENCE.

℞ Strychninae Sulph. ....gr. 1-30
Hydrastinae Hydrochlor. ....gr. 1-4
Ergotini ......gr. ij
M.f. caps. No. I. D. tal. dos. No. LX.
S. One capsule 2 or 3 times a day after meals.

℞ Tabellae Styptol āā gr. j (0.05) No. XXX
S. One t.i.d.
℞ Tab. Hydrastininae (synthetic, Bayer) No. XXX.
S. One t.i.d.

℞ Styptol ....gr. j
Extr. Ergotae ....gr. jj
Strychninae Sulph. ....gr. 1-30
Pulv. Cinnamomi. gr. j
M.f. caps. No. I. D. tal. doses No. XXX.
S. One t.i.d.

℞ I. Aetheris Acetici, ℥jss
Ol. Rosmarini..ʒij
Ol. Origani ....ʒij
II. Ammonii Chloridi ....℥viij
S. ʒj of the liquid and ℥ss of the powder in pint of water, to be used for ablution of the genitals at night, or night and morning.

Instead of Ammonium Chloride we may use equal parts of Ammonium Chloride and Magnesium Sulphate.

℞ Chloroformi
Tr. Belladonnae...āā ℥i
S. Paint as directed with camel's hair brush.

℞ Chloroformi ....℥j
Tr. Capsici ....ʒij
Tr. Belladonnae ....ʒvi
S. Paint with camel's hair brush.

℞ Strychninae Sulph., gr. i
Hydrastinae Hydro-
chl. ....gr. x
Aquae Destill. gtt 400
S. One to four drops in the prostatic urethra by the aid of a Guyon syringe.

As it is sometimes difficult to obtain a hydrastine hydrochloride of high quality and which is clearly and readily soluble, I have frequently used hydrastinine hydrochloride instead, and with equally good results. Lately I have been using synthetic hydrastinine exclusively.

Phosporus Pills

Personally I have no faith in elementary phosphorus, but if a physician should desire to give it a trial it is best prescribed in the form of pills of the U. S. P., each containing $\frac{1}{100}$ gr. of phosphorus.

℞ Phil. phosphori, U. S. P., No. LX
S. One t.i.d., p.c.

℞ Morphinae Sulph. gr. $\frac{1}{4}$
Atropinae Sulph. gr. $\frac{1}{120}$
Ol. Theobromatis gr. XXV
M.f. Suppos. No. 1
D.t.d. No. XII
S. Insert one half an hour before coming to the doctor.

Some patients are extremely sensitive even to the gentlest prostatic massage. To such patients I order the above suppositories, with instructions to insert one on leaving for my office. It makes the massage, as well as any urethral instrumentation, much less painful.

℞ Tr. Capsici ....ʒi
Tr. Zingiberis ......ʒi
Tr. Cinnamomi ....ʒiv
Spir. Vini Gallici q.s.ad ....℥iv
S. ℥ss-℥i as directed.

℞ Gran. Cantharidini gr. $\frac{1}{500}$
(Abbott Alkal. Co.) No. 500.
S. One every hour, until slight symptoms of irritation at the neck of the bladder appear. Sometimes I order as many as five granules at a

dose. Some people are very sensitive to cantharidin, and cannot stand more than 1/1000 of a grain.

℞ Gran. Arbutini...gr. 1/6 (Abbott Alkal. Co.) No. 200.
S. Two or three every 2 hours.

℞ Tabell. Yohimbini
āā gr. 1/12, No. XX
S. One or two tablets as directed.

Though as stated I have but little faith in Yohimbin, still as it occasionally *seems* to possess some virtue, we have no right to deprive the patient of its possible benefit. I state frankly that I often prescribe drugs about whose efficacy I am very skeptical. But if I know that the drug is not injurious, and if in a certain number of cases it seemed to do good, and if it is vouched for by some confidence-inspiring clinicians, then I do not consider myself morally justified in depriving my patient of its possible beneficial effect. I give it at least a trial. But I never give Yohimbin as a routine remedy, to be taken for several days in succession. I only give one or two tablets on the day of intended intercourse, generally two or three hours before. Sometimes I prescribe it to be taken in conjunction with strychnine: 1/12 gr. tablet of Yohimbin with one 1/20 gr. tablet of strychnine. *But it must never be given to patients with any heart disease.*

℞ Zinci Phosphidi..gr. 1/10
Auri et Sodii Chloridi gr. 1/10
Strychn. Sulph...gr. 1/24
Calcii Glycerophosph. gr. v
M.f. caps. No. 1. D.t.d. No. XXIV.
S. One t.i.d., p.c.

SEXUAL NEURASTHENIA

℞ Arseni Trioxidi, gr. 1-30
Strychninae Sulph. .... gr. 1-20
Calcii Glycerophosphatis ....gr. iij

Massae Ferri Carbonatis ....gr. ij
m.f. caps. No. I. Tal. Dos. No. XXX.
S. One t.i.d. p.c.

℞ Tab. Sextonol No LX.
S. One or two tablets 3 times a day.

℞ Syr. Hypophosphitum Comp. ....℥iv
S. ʒj in water t.i.d. p.c.

Prof. Barrucco, who wrote one of the best monographs on sexual neurasthenia, distinctly specifies Fellows' Syrup of Hypophosphites. And some patients claim they derive more benefit from Fellows' make than from the official kind, or from the extemporaneous mixtures made up by druggists. It is also generally better borne by the stomach. And our neurasthenic patients are so capricious that the least thing makes a difference with them.

℞ Phosphagon ......℥viii
S. ʒj or ʒij in water t.i.d. p.c.

Where anemia is a prominent feature, I still find Gude's Peptomangan one of the best hematinics and I prescribe it freely in spite of the growls of well-intentioned doctrinaires and narrow-minded bigots, and I even go so far as to insist upon an original bottle. The numerous attempted substitutes are generally abominations and should be left alone by the physician.

As stated in the text, one of the important points in the medicinal treatment of neurasthenia is to change the remedies frequently. We have a large field to choose from; in fact, we have an *embarras des richesses.* We can prescribe the numerous lecithin preparations (neuro-lecithin, ovo-lecithin), sanatogen, Wheeler's tissue phosphates, comp. elixir of glycerophosphates, neurophosphates, phospho-albumen comp, neurotonic tablets, etc.

℞ Caps. Brovalol, No. XX
S. One or two 3 times a day.

℞ Caps. Bornyval, No. XX
S. One or two 3 times a day.

℞ Zinci Valeratis.
Ferri Valeratis.
Quininae Valeratis.
Extr. Sumbul...āā gr. i
M.f. pil. No. 1. D.t.d. No. XXX.
S. One t.i.d., p.c.

℞ Tab. Hyoscini Hydrobrom. ....gr. 1/100
No. XXX.
S. One on going to bed.

In severe cases one dose may be given at 8 p. m. and one on going to bed.

IN FRIGIDITY, MALE AND FEMALE

℞ Ext. Cannabis Ind. Fl. ʒi
S. As directed.

I do not state here any definite dose, because Cannabis Indica must be prescribed according to the effect it produces. Some are very sensitive, some can stand enormous doses. The text book doses are worthless. I start with 3 minims of a good fluid extract, gradually increasing to 5, 10 and 15 minims, going in some cases even higher. I tell the patient to relate to me his symptoms, and by the symptoms I judge whether or not to continue the drug. The drug is generally to be taken in the evening. In some patients the effect of the drug is a strongly erotic one, in others it only causes gastrointestinal disturbance and a splitting headache.

STERILITY

℞ Ung. Hydrarygri ....ʒi
Adipis Lanae ......ʒix
M.f. ung.
S. Use as directed.

This makes an ointment containing five per cent of mercury. If we wish to prescribe a ten per cent ointment, then we prescribe 2 drams of unguentum hydrargyri with 8 drams of adeps lanae. I use the non-hydrous woolfat as a base, because this makes an ointment of rather solid consistency and permits a good deal of rubbing before it begins to run.

℞ Ung. Potassii Iodidi
U. S. P.

Adipis Lanae ....āā℥ss
M.f. ung.
S. Use as directed.

℞ Plumbii Iodidi ....ʒss
Adipis Benzoin.......ʒv
Adipis Lanae ......ʒv
M.f. ung.
S. Apply with thorough massage every other night.

℞ Camphorae ....ʒss
Oleores. Capsici ...gr. v
Adipis Lanae ......℥ss
Petrolati ....℥ss
M.f. ung.
S. Rub in small quantity every night. Wash off in the morning with soap and water and apply some talcum powder.

℞ Camphorae ....ʒss
Pulv. Capsici ....ʒj
Ol. Sinapis ....gtt v
Petrolati ....ʒj
M.f. ung.
S. Rub in small quantity every night or every other night. Wash off in the morning with soap and water and apply some talcum powder.

℞ Tabellae Protonucleini No. LX
S. Two tablets 3 times a day.

IN PRIAPISM, CHORDEE, ETC.

℞ Morphinae Sulph..gr. 1/3
Antipyrini .....gr. v
Atropinae Sulph. gr. 1/100
Ol. Theobrom. gr. xxx.
M.f. Suppos. No. 1
D.t.d. No. XII
S. One suppository at night, or every other night.

This is a pretty strong suppository, but in priapism or in very obstinate erections we can expect an effect from large doses only. In some cases I give as much as 1/2 gr. morphine to each suppository.

For Leukemic Priapism

℞ Benzol (not benzin) .℥i
Ol. Olivae ....℥i
Div. in caps. No. LX
S. One capsule t.i.d., or 15 minims may be measured out into a teaspoon.

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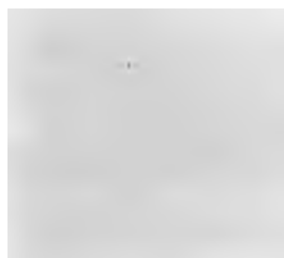

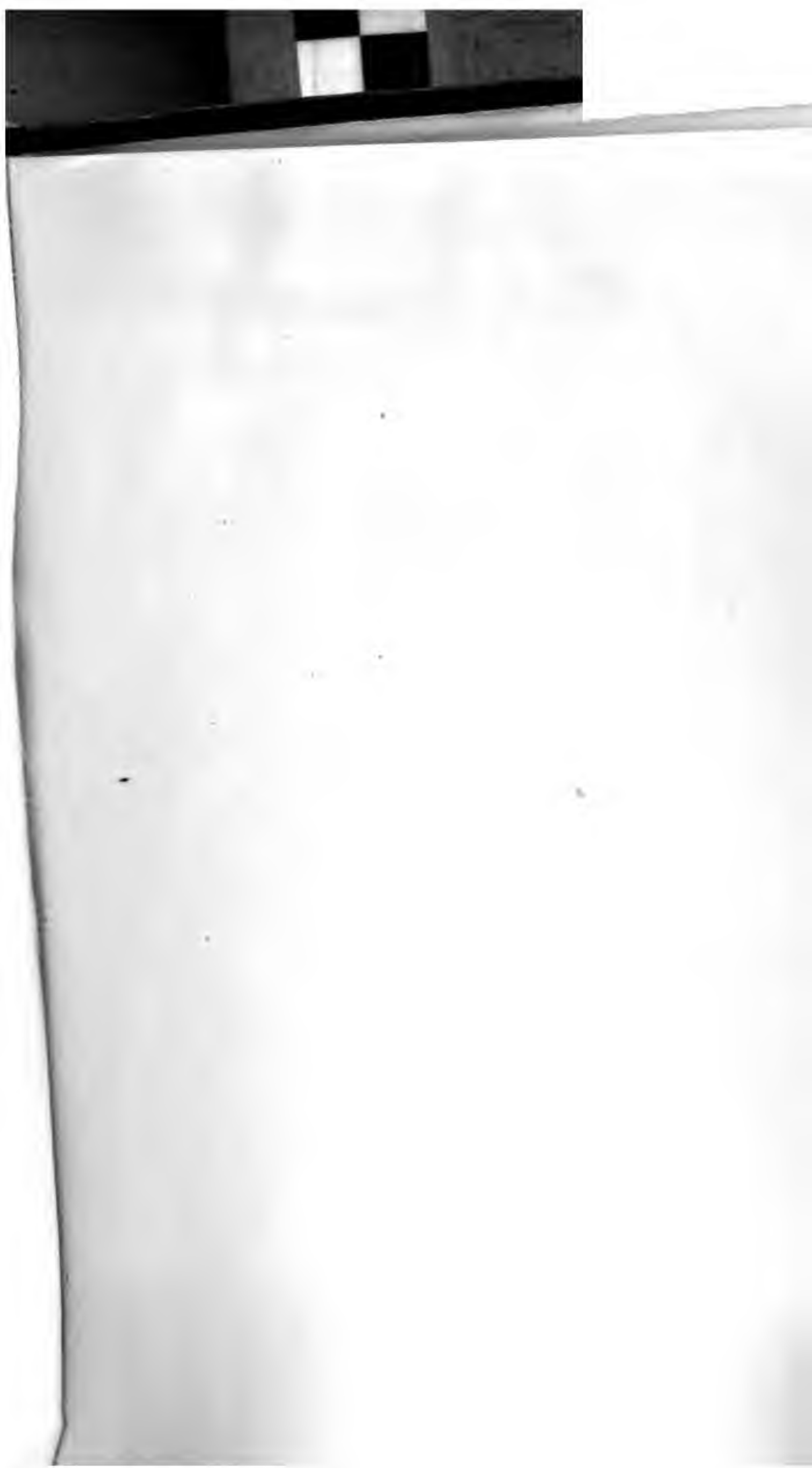

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